Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11, per Fh g903.5/7/10 TT
State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Clifford H. Kidd April 2<sup>tr</sup>, 201<sup>tr</sup> 12:45AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death
Baltimore **Examiner** Towson Gilchrist Hospice . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year 1 🔀 M 2 🗆 F Months 93 1916 Maryland 217-07-4707 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1X Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 3405 Rosalie Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ò 1 Never Married 2 5 M Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify. "natural", Completed 3 XWidowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bowling Entrepreneur 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pearl Haynie Harry Kidd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Latimer Road-Joppa, Maryland 21085 Diana Kidd-daughter 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State netery, crematory or other place Holy Redeemer Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Apr. 24,2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Exams Funeral Chamel and Cremation Services 8800 Fartord Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximate Interval Between Onset and Death CANCON Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confidence in the continued to the Funeral Director. attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 1 ∐ Yes 2 L 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 욘 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUON HANUS 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Ruth Klein Physician/ Month 12: 40AM 20/0° Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Keswick MultiCare Center Baltimore N/A . Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign MD Country) **Funeral** 1 □ M 2 Months Days Hours Min. Feb 3, 191 Director 213-03-3070 97 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD N/A Baltimore 1 XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 Roland Avenue Apt. 223 21211 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes XX No Black, White, etc XX Never Married 2 Married þ Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 XX No Specify White "natural", Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Bookkeeper Elementary/Seconday (0-12) College (1-4 or 5+) Jewelry Store permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Klein Martha Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois McNelly (Friend) 3838 Roland Avenue Apt. 1011 Balto, MD 21211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State 4/20/10 Baltimore, MD Woodlawn Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Dicensee 22. Name and Address of Facility 3631 Falls Burgee-Henss-Seitz Funeral Balto,MD 21211 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Demonta disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Month Dav signed by the at d be detached for 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DS4copprosis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 2 V No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) / Hospites ... 124 hours after death. • Funeral Director: After this ce Hospital: Other: ၉ 1 Yes^ 2 14 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined building, etc. (Specify) 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

within 24 h To the Fur

State Registrar 29b. Signature and title of certific

MISMERIE

> Marbelle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

MACGREGOR, TOOW 40 th STREET,

32. Registrar's Signature

29c. License number

D13657

april 20, 2010

BALTIMORE, MD 21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  | 1 - For State Registrar  | State of Maryland   |   | ficate of De  |   |   | eg. No.                                       | 12503  |
|--|--|---|---|---|---|---|---|--|
| Physician<br>/Medical  | Hallee S Konny   |   |   |   |   | 2. Date of Deat<br>Month<br>April             | Day Year                                      | 3. Time of Death<br>8:30 AM <sup>M</sup>           |
| Examiner   | 4a. Facility Name (If not institution, give 5679 Harpers Fa  | rm Road #A  |   | c. City, Town, or Lo  | ia  |   | 4c. County of Deat                            | l  |
| Funeral<br>Director  | 5. Social Security Number 6. Sec. 226–32–8400  | 7. Age (In yrs. la  |   |   | Hours Min.                                      | 8. Date of Birth<br>(Month, Day,<br>June 22   | 9. Birt<br>(Co<br>Vir                         | nplace (State or Foreign<br>untry)<br>ginia        |
| or 28a-f show<br>be notified at  | 10a. State 10b. County   |   | Town or Location                          | on  |   |   |   | 10d. Inside City Limits 1 ☐ Yes 2 No               |
| 23a or 28<br>int by no   |  | Road: Apt A   |   | 10f. Zip Code 21044   |   | 1   | 0g. Citizen of What Co<br>USA                 | untry?   |
| annexed other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evaluation count by notified at To Be Completed by Funeral Director  | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1  |   | S Decedent of Hispa<br>es, specify Cuban, I<br>Yes 2X No S      | anic Origin? (Sp<br>Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)              | 14. Race - Ame<br>Black, White<br>Specify: Wh | , etc.   |
| other than "natura<br>rent, the Medical E  | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | cation<br>e completed)<br>College (1-4or 5+)  | (Give kin<br>life. DO                     | t's Usual Occupation of work done during NOT use retired) ander | on<br>ing most of work                          | ing   | 16b. Kind of Business/                        | ndustry  |
| arked other atic event, it   | 17. Father's Name (First, Middle, Last)  | hepherd   | Darce                                     |   |   | e (First, Middle, M<br>Anderso                | taverns<br>Maiden Surname)<br>on              | <u>, , , , , , , , , , , , , , , , , , , </u>      |
| r trauma   | 19a. Informant's Name/Relationship (Ty<br>Crystal Konny/dau  |   |   |   |   |   | ; City or Town, State, 2<br>Maryland          |  |
| any injury or other traumatic evonce.  | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☑ Donation 5 ☐ Other (Specify)   | emoval from State   | ace of Disposition<br>ace metery, cremate | on (Name of<br>ory or other place)                              |   | Date  | 20c. Location - City or                       | Fown, State  |
| any Inj<br>once.   | 21. Signature of Emperal Service Licens  | had Wrector   | Sta                                       | ame and Address of<br>te Anatom<br>timore, M                    | y Board   | ; 655 W.                                      | Baltimore                                     | Street   |
| cian<br>dical  | 23a. Part 1 Enter the disease, or complishock for heart failure. List only or Immediate Caire. (Final disease or condition resulting in death) | cations that caused the death. le cause on each line.  ESOPh  Due to (or as a conseque            | aseal                                     | 0   |   | or respiratory arre                           | est,  | Approximate<br>Interval Between<br>Onset and Death |
| as the burial-transit  |  | Due to (or as a conseque  | ence of):                                 | -,  |   |   |   |  |
| letached for use as Physician/Med  |  | 3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of de 9 □ Unknown | death 3 E                                 | ctopic pregnancy<br>ther (specify)                              |   |   | 23d. Date of del<br>Month                     | very<br>Day Year                                   |
| old be deta  | Tarrii. Other significant conditions con   | tributing to death but not result   | ting in the unde                          | rlying cause given i  | n Part I.                                       |   | pacco use contribute to                       | the cause of death?                                |
| or, page 2 should  |  |   |   |   |   | 24a. Was ar<br>autops<br>perforn<br>1 🗆 Yes 2 | y prior to o<br>ned? death?<br>2⊠No 1 □ Yes   | topsy findings available completion of cause of    |
| al directo   | examiner?  | ospital: 1  Inpatient 2 E   | ER/Outpatient                             | Other   |   | h <i>(Check only one</i><br>me 5 Reside       | e)<br>ence 6 □Other (Spe                      | cify)  |
| On the Land of the | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be   | (Month, Day, Year)  |   |   | 2 □ No  |   | w injury occurred                             |  |
| filled in by   |  | 28e. Place of Injury - At hon building, etc. (Specify)  | )   |   |   | City or Town                                  | ,   |  |
| o the Fune<br>ompletely fi   | (Check only 2   Medical Examination one)   | sician: To the best of my knowner: On the basis of examination and manner stated.                 | on and/or inves                           | tigation, in my opini   | ion, death occur                                | red at the time, d                            | ate and place, and due                        | to the cause(s)                                    |
| <u>P</u> 0   2   | > nucharl 13   | eund  |   | 29c. License nu   | -6287   |   | 9d. Date signed (Mont) 4/(5//0                |  |
|  | 30. Name and address of person who co  | and 7305  |   | more Bl   | 1 107   | Colle   | ge PAil N                                     | US 20740   |
| State  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signatu   | ire A A                                   | ake   |   |   |   |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APRIL Vear **Physician** 06.10 PM ctavio 10 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNES BALTIMORE HOWITAL 51. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🛣 F Months arolina Director 7-12-032 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Macical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent I Armed Forces? Black, White, etc. 1 Yes 2 Yo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. à Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+ Elementary/Secondary (0-12) 17 Father's Name (First, Middle, Last) Be sknown ဂ္ Informant's Name/Relationship (Type. Profit) Daug Lter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Baltimore, 20c. Location - City or 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ R 4 Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death , such as cardiac or respiratory arrest, Immediate Cause (Final Physician FEW DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIFFICILE COLITIS CLOSTRIDIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed the attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Hlnknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ RENAL FAILURE 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Wasan autopsy performed? Yes 241No certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Tospital or Attending P 4 hours after death. Funeral Director: After t 1. Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours Funerai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0062634 APRIL 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEISN ALLAN 10802 HICKORY RIDGE RD COLUMBIA MO 31. Date filed (Month, Day Year) 2 2010 gistrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Sister Isabel Liegus 04 2010 10:45p /Medical 14 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4130 Maple Avenue Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/14/1911 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔀 F 98 Days Hours 191 40 5531 Pennsylvania Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Baltimore 5 4 1 Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23¢ or 4130 Maple Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after ☐Yes 2 🛣 No Yes, Give 1 Never Married 2 Married 50 Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced White "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 I al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Religious Sister Unknown Religious 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is markad ott Be John Peter Liegus Josephine Karpacuite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health : Sister Mary Becker 4130 Maple Avenue Baltimore, Maryland 21227 othar t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Itel any injury or oth 1 Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 04/17/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature prundral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ALVIC MY /Medical Due to (or as a consequen y of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical the IF FEMALE: nse n 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Ö detached 9 Unknown þ م l be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate Division of Vital 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 🗌 Yes 2 **N**o 4 ☐ Nursing Home 5 Viesidence 6 ☐ Other (Specify) 27. Manne f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attanding 1 atural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: A 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a pellil Hospital 1 🐼 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Defining repaired. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number son who completed cause of death (Item 23a) (Type, Print) MB 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1tem 2 per dvr g902 4-22-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2010 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 5:50p M 17, Lucas Nancy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Dundalk 3110 Ardee Way 8. Date of Birth (Month, Day, Year) 6-17-1936 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 🗗 F Months Days Hours 73 Pennsylvania 215-32-9384 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Wedical Experience must be notified at 1 ☐ Yes 2 💆 No Director Dundalk Md. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, 101 Center Place Apt. 111 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2₹ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. à White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier A & P N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (UNK) Adam Yandrich Dorothy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7929 Trappe Road Dundalk, Md. <u>Edward Lucas, Jr. (son)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 21, Baltimore, Maryland ₩ Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 200 1201 Dundalk Avenue Baltimore, MD 21222 Approximate Interval Between Qnset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** car /Medical Due to (or as a cont equence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ne To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2 No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter-in-Law 6 Klother (Specify) Home Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 920 32. registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:05 AM Apr. 1 010 /Medical Dayin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Centr Hosp-La 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/23/1938 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12M 2DF Months Days Hours Min. 219-26-6063 MD Director 7/ Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f shov event, the Medical Examinating the notified at by Funeral Director 1 □Yes 2 X No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene. 27 CARAWAY ROAD 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify Specify: 3 Wildowed 4 Divorced WHITE Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) of Health and Mental Hygiene. **PHARMACIST** PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEVIN BENJAMIN ANNE SOKOLSKY or other traumatic ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA LEVIN / WIFE 27 CARAWAY ROAD, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of Important: If its any Injury or o 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN 04/21/2010 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lic 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a. Alene core mene /Medical Due to (or as a consequence of): **Examiner** Primary Untrow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate ! 1 ☐ Yes 2 ☑ Ño 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation spital or Attendliours after death.
neral Director; A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

APR 2.2.2010

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J

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2908

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ crome :00 AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death Himore Funeral 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 MM 2 🗆 Director ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No mh timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ► Never Married 2 ☐ Married à Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ther's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau vette M. Baltimore, Method of Disposition 20b. Place of Disposition (Name of Page 1 a 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee C. Greene Funeral Services 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Atheroselesghe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? ģ Month Pregnant at time of death g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Tes 2 No Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be within 24 hours after death To the Funeral Director: Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALSHAW. S. SALUJAM1682 (Kerry turn to 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Jean Kathleen Martin 2010 April 2:20 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Baltimore County Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 8 Date of Birth 7 Age (In vrs. last hirthday) **Funeral** 1 □ M 2 🔀 Days Hours Min. (Month, Day, 213-66-9823 56 Director <u> August</u> Albuquerque, N.M. Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 Yes 2 XNo Maryland Howard County Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6112 Cedarwood Drive 21044 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 ☐ Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Completed Year or Dates er than "natura , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Howard County Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. Elementary/Seconday (0-12) College (1-4 or 5+) School District High School Physics Teacher 12 06 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Waldo Martin Beverly Lee Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 Ms.Lee M. Kladky (Twin Sister) 214 Purlington Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 22, (Harford Co.) Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. Deffrey L. Gair, Sr. 2325 York Road Timonium, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition METASTATIC BREAST CANCER Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury -transit requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical as t IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No for Year Month Day 1 Yes 2 9 Unknown the detached 9 I Ilnknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has page 2 Yes 2 X No 2 🗍 No 1 Yes Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes ျှ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? nours after death.

neral Director: After the filled in by the funera 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🔀 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou **To the Fune** completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 164395 APRIL 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 6701 N CHARLES ST, SUITE 4105 BALTIMOREIMO 21204

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regisear's Signature

| 10-030  | 02       |
|---------|----------|
| Jeffrey | Mitchell |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ffrey Mitchell   |                  | 1- For State   | tate of Maryland                                       |                              | tment of He<br>ficate of De                |                                     | d Mental H               |  | 2. U                        | 10 1201   |
|--|------------------|--|--|------------------------------|--|-------------------------------------|--------------------------|--|-----------------------------|---|
| Physicia   | _                | Registrar  1. Decedent's Name (First, Mide   | dle,Last)  |                              |  |                                     |                          | 2. Date of Death                               |                             | 3. Time of Death  |
| edical Exami   |                  | Jeffrey  | Wa   | yne                          | 1  | Mitch                               | ell                      | Month<br>April 17, 20                          |                             | 1057 hrs  |
|  |                  | 4a. Facility Name (if not instituti<br>Union Memorial Hosp                                     |  |                              |  | ty, Town, or I<br>I <b>ltímor</b> e | Location of Death        | 1  | 4c. County of D             | eath  |
| Funeral  |                  | 5. Social Security Number  | 6. Sex 7. Ag   | e (In yrs. last              |  | Jnder 1 Year                        |                          |  |                             | . Birthplace (State or oreign                             |
| Director   |                  | 214-50-2556  | 1X M 2 F   | 63                           | Yrs.                                       | onths Days                          | Hours Min                | 01 2   | 9 47                        | Country) MD   |
| any .  | ŀ                | Usual Residence of Decedent  10a. State  10b. County   |  | 10c. City, To                | own or Location                            |                                     | · · ·                    |  |                             | 10d. Inside City Limits                                   |
| Maryland<br>28a-f show<br>d at once.   | 5                | MD M   | IÀ   |                              | Baltime                                    |                                     |                          |  |                             | 1 X Yes 2 No  |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.   | irect            | 10e. Street and Number Presbury  | 7  |                              | 10f.                                       | Zip Code                            | 1016                     | 10   | g. Citizen of What          |   |
| 215-0036 be filed within 72 hours after death with the Maryland ntal Hygene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once | Funeral Director | 2904 Presbut   | Street 12. Was Decedent                                | Ever in U.S.                 | 13. Was Dec                                |                                     | 1216<br>panic Origin? (S | pecify Yes or No-                              | U . S                       | merican Indian, 8lack,                                    |
| death v  | nue              | 1 X Never Married 2 N  | Armed Forces  1 X Yes 2                                |                              |  |                                     | , Mexican, Puerto        | Rican, etc.)                                   | White, et                   |   |
| s after<br>ral", o   | J.               | 3 Widowed 4 Di   | vorced If Yes, Give Year or Dates:                     | anlatad\ 14                  | 1 Yes                                      | 2 X No                              |                          | work done                                      | Specify: B                  |   |
| )36<br>thin 72 hour<br>te.<br>than "natu   | eted             | Elementary/Secondary (0-12   |  | · ·                          |  |                                     | DO NOT use ret           |  | TOD. KING OF BUSIN          | soon industry   |
| 21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat c event, the Medical Exa  | Completed        | 12th grade   | na   |                              | Labo                                       | rer                                 |                          |  | Various                     | Jcbs  |
| 21215-003 ould be filed within I Mental Hygiene, marked other the ic event, the Media  |                  | 17. Father's Name (First, Middle   |  |                              |  |                                     |                          | e (First, Middle, M                            |                             |   |
| 5 9 9 g 5  | o Be             | Isaac Mitche 19a. Informant's Name/Relation  | ship (Type, Print)                                     | -                            | 19b. Mailing Add                           | ress (Street                        | t and Number or I        | r Marsh<br>Rural Route Numl                    | all<br>per, City or Town, S | State, Zip Code)  |
| s, MD 21 and 2 should lealth and Me tem 27 is ma   |                  | Eleanor Mito   | chell-Mothe  | r _                          | 2904 <del>Pi</del>                         |                                     | ro Stre                  |  | <u>ltimore</u>              | , Md 21216  |
| imore, MD 2 Pages 1 and 2 shou nent of Health and N sant: If item 27 is n or other traumatic   |                  | 20a. Method of Disposition  1 X Burial 2 Crematic  |  | 20b. Pla                     | nce of Disposition (<br>matory or other pl |                                     | netery,                  | Date   | 20c. Location - Cit         | y or Town, State  |
| Baltimore,<br>permit. Pages l ar<br>Department of Hee<br>Important: If ite   |                  | 4 Donation 5 Other S   | Specify:   |                              | rison F                                    | orest                               | Vet 4                    | /27/20   | lO Owinc                    | s Mills, M  |
| Bal<br>permit<br>Depar<br>Import<br>injury   | Į                | 21. Signature of Funeral Service   | V as I do  |                              | Marc                                       | h F/H                               | of Facility West         | . Balti  | more, m                     | d 21215   |
| Physician  |                  | 23a. Part I. Enter the disease, of failure. List only one caus                                 | r complications that caused                            | the death. D                 | o not enter the mo                         | ode of dying,                       | such as cardiac          | or respiratory arre                            | st, shock, or heart         | Approximate Interval<br>Between Onset and                 |
| /Medical<br>Examiner   |                  | Immediate Cause (Final diseas  | a Hypertens  |                              | heroscle                                   | rotic                               | cardiov                  | ascular  | disease                     | Death   |
| _ &  |                  | or condition resulting in death)   | Due to (or as a cons                                   | equence of):                 |  |                                     |                          |  |                             |   |
|  | ē                | Sequentially list conditions,<br>if any, leading to immediate<br>cause. Enter Underlying Cause | Due to (or as a cons                                   | equence of):                 |  |                                     |                          |  |                             |   |
| _  | Examiner         | (Disease or injury that initiated events resulting in death) Last                              | c.  Due to (or as a cons                               | equence of):                 |  |                                     |                          |  |                             |   |
| ecuted<br>and<br>- transit   | ia<br>E          |  | d10e   | £ 101                        | ner Fl                                     | - 903                               | 5/12/10                  | Trip   |                             |   |
| Sox 68760,<br>death certificate be executed<br>e attending physician and<br>I for use as the burial - trans  | ledical          | X UNPENDED   | X AMENDED 106<br>23a, 27,                              |                              |  | 3/10 7                              | TT T                     |  | 23d. Date of del            | ivery   |
| 6876<br>certificate<br>nding phy<br>se as the b  | an/N             | IF FEMALE:<br>23b. Was decedent pregnant in<br>past 12 months?                                 | I LIVE DITTI   |                              | 2 Fetal de                                 | ath 3                               | Ectopic pregna           | ancy   | Month                       | Day Year  |
| Box 6876( e death certificate the attending phy ed for use as the b  | Physician/N      |  | 14 Pregnant at<br>19 Unknown                           | time of death                | other (                                    | Specify)                            |                          |  |                             |   |
| O. E.  |                  | Part II. Other significant cond  |  | h but not resu               | ulting in the underl                       | ying cause g                        | jiven in Part I.         | 23e. Did tot                                   | pacco use contribut         | e to the cause of death?                                  |
| Pe Sign  | d by             |  |  |                              |  |                                     |                          | 1 Yes  |                             | Probably 4 V Unknown                                      |
| cords,<br>law requir<br>has been s   | plete            |  |  |                              |  |                                     |                          | 24a, Was a autops                              | y prior                     | e autopsy findings available<br>to completion of cause of |
| Re The cate  | Completed        |  |  |                              |  |                                     |                          | perform<br>1 Yes 2                             |                             | Yes 2 No  |
| /ital Reoysician: The his certificate director, page   | a                | 25. Was case referred to medic examiner?   |  | ent 2 🗸 Fi                   | R/Outpatient 3                             |                                     | of Death (Check          |  | Residence 6                 | Other.  |
| of Viing Physi   | <u>د</u>         | 1 Yes 2 No<br>27. Manner of Death  | 28a. Date of Inju<br>(Month, Day,                      | iry 2                        | 8b. Time of Injury                         |                                     | y at Work?               | <u> </u>                                       | ow injury occurred          |   |
| ion<br>tendii<br>leath.<br>tor: /  | aţio             |  | nding estigation                                       | ear)                         |  | 1 Y                                 | res 2 No                 |  |                             |   |
| Division<br>ral or Attendi<br>rs after death.  | Certification:   | 3 Suicide 6 Cou  |  | njury - At hom               | e, farm, street, fac                       | tory, office b                      | uilding, etc.            | 28f. Location (S<br>or Town, St                |                             | r Rural Route Number, City                                |
| Divis  To the Hospital or At within 24 hours after d  To the Funeral Direc completely filled in by   |                  | 29a. Certifier 1 Certifying I  | Physician: To the best of maminer: On the basis of exa | y knowledge,<br>mination and | , death occurred a                         | t the time, da                      | ate and place, and       | f<br>d due to the cause<br>at the time, date a | e(s) and manner as          | stated.<br>to the cause(s)                                |
| To t<br>with<br>To t   | Medical          | 29b. Signature and title of certif   | and manner stated.                                     |                              |  | 29c. License                        |                          |  |                             | (Month, Day, Year)  |
|  |                  | Panik 98   | uther, mi)   |                              |  | O.C.                                | M.E.                     |  | April 18, 2010              | )   |
| 7  |                  | 30. Name and address of person Pamela E. Southall,   | MD Assistant Med                                       |                              |  | enn Street                          | t, Baltimore, I          | MD 21201                                       | -                           |   |
| /  | ate              | 31. Date filed (Month, 1977) Year  | 32. Registra   | r's Signature                |  |                                     |                          |  | -                           |   |
| Regist   | rar              | AFR 2  | 2 2010   Sens  | ue,                          | 1. San                                     |                                     |                          |  | CCM                         | F   |
| DHMH 17 Rev 1/2  | 001              |  | -  |                              | ORIGINAL                                   |                                     |                          |  | COM                         | har   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April OLIOA M 2010 Marva Z. McCullough Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimon Washington Metal Glen BURNIC (enter If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days March 3 1 □ M 2 🗱 F Hours West Virginia 1944 Director 232-70-4020 66 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits death with the Maryland **Funeral Director** XX Yes 2 No Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2401 Lizbec Court 21114 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Office of Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Specialist Personnel Management Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ram Robinson Olivia Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Christopher McCullough/ Son PO Box 1327 Bowie, MD 20715 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u> Lincoln Cemetery!4/23/2010 | Brentwood, MD</u> 22. Name and Address of Facility Robert E. Evans Funeral Home Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ onces for Heart disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cell Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Que the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Renal FA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached fo 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No hin 24 hours after death.

the Funeral Director: A
npleted filled in by the for Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Tertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier lein Irm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP BA Hmore Henry ANCIS Washing ton 31. Date filed (Month, State Registrar

DHMH 17 Rev 7/2009

Mccullough, Myrus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2512 Certificate of Death Reg. No. Name #First, Middle, Last) 2. Date of Death 3. Time of Death Decedent's **Physician** 10:08 /Medical Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 🗆 M 2 😾 F Days Yrs. 217-80-4464 **Director** 10/30/64 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Baltimore 1 □Xes 2 □ No Director MD N/A 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3402 Lyndale Ave USA 21213 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Examiner 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Asbacit can ģ Amer Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Social Sec Adm Benefit Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Mallory, Sr. Shirley Oliver ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latosha Daughter 603 Gold St., Balt., MD 21217 <del>Latasha</del> Anderson/<del>Daufgt</del> permit. Pages 1 and Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk 4/22/10 Balt., MD 21. Signature of Fun- al Service Licenses 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 <u>Belair</u> Rd, Balt., MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician dissection 4ortic disease or condition resulting in death) /Medical Examiner pertension Sequentially list conditions, iner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami to the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) nding physician Division of Vital Records, P.O. Box 68760, Physician/Medical E FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Yea Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 □ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Director: After to d in by the funer 1 Natural 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after hours 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 one) To the within 2 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonnie 600 North Wolfe St, Baltimore, MD, 21287 Lonze 31. Date filed (Month, Day, Year)\_ 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day McKenzie 2010 rear Marie Geneva 6:47 pri1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Jan 27.1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 Washington 79 **Director** 244-70-1296 931 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges 1 Yes 2 YN No Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 9118 Goldenrod Lane USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, , or ) Completed by 1 Never Married 2 Married 1 Gres 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", White 3 Widowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Server Education 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) May Elsie Griffith Raymond E. Glascoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9115 Marlboro Pike Lot 59, Upper Marlboro, MD 20772 Donna Huff- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD MarylandVeterans Cemetery 2010 of Smeral Service Signature 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd, Clinton, MD 20735 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on eath line mmediate Cause (Final Ph sician/ Medical resulting in death) Examiner Esquantiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown be detached 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending within 24 hours after death. To the Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🌋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and on investigation, in my spiritum, doctors as the distribution of the basis of examination and one to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. W. SOTS C. R.D., 12070 C.D. OD UVE CENTER Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ MATTHEWS 12:30 AM FRANK 2014 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BAYVIEW MEDICAL ENTER JOHNS HOPKINS N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 63 Days 0570871946 Maryland **Director** 212 46 7676 Usual Residence of Decedent or 28a-f show 10a. State 10h County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Baltimore Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 - 5th Avenue 21225 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Viet Nam White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HRR Painting Contractor Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Bergner Robert Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Matthews / Wife 107 - 5th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 04/21/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) HERATORENAL Medical Due to (or as a consequence of): **Examiner** PERITON MIS 1226 BNJANEOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir BLEED north the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pendina thin 24 hours after death.

the Funeral Director: A

mpleted filled in by the for Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number RES-000 2010

State Registrar

DHMH 17 Rev 7/2009

EASTERN

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

4940

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Michael Martin 12:30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Hospice 5. Social Security Number 7. Age (In yrs. last birthday) 59 Yrs. If Under 1 Year | If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Month, Pay, Yar) 50 Maryland 220 48 6951 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 🔀 No Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral 21227 U.S.A. 5112 Leeds Avenue Apt. 6 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Phone Technician Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John Martin Irene Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5112 Leeds Avenue Apt. 6 Baltimore, Maryland 21227 Juanita Fischer / Friend Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem. Park 04/19/2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a art 1. Enter the discontrol or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiomyopath END-STAME Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 🔲 Yes 2 1 N Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No 1 Matural 5 Pending 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 Smith Av., S-203-Baltimore, MD 21209

Registrar DHMH 17 Rev 7/2009

State

Registrar's Signatu

N. S. Rajupakse, M.D.

31. Date filed (Month, Day, Year,

|                   |  |                 | Please  | Type or Pri<br>AMEND IT<br>State of M                                     | <b>nt in Bla</b><br>EM#3pei<br>arvland / | PHYS<br>Depa              | i <b>delibl</b> e<br>G902<br>artment | e Ink.<br>of He       | Ensure (<br>0/2010, i<br>ealth and (            | <b>All Copie:</b><br>VS<br>Mental Hv  | <b>s Are</b><br>aiene | Legible                                       |   |
|-------------------|--|-----------------|---|---|--|---------------------------|--------------------------------------|-----------------------|---|---------------------------------------|-----------------------|---|---|
|                   |  |                 | State Registrar   |   |  |                           | tificate                             |                       |   |                                       | Reg. No.              | 7016  | 12310   |
|                   | Physicia   |                 | 1. Decedent's Name (First, Middle, Las<br>Stephanie Deane   |   |  |                           |                                      |                       |   | 2. Date of De                         | ath<br>22             | , 20 <b>1</b> 0                               | 3. Time of Death 12:58 T                          |
| -                 | Medic<br>Examir  |                 | 4a. Facility Name (if not institution, give   | street and number)  |  |                           |                                      |                       | ocation of Death                                | 1                                     |                       | County of Deal                                | h   |
|                   | Funeral  |                 | Gilchrist Cente 5. Social Security Number 6. S  | ex 7 Ao   | e (In yrs. last b                        | irthday)                  | If Under 1                           |                       | f Under 24 Hrs.                                 | 8. Date of Birt                       | th ,                  | 9. Bir  | imore thplace (State or Foreign                   |
|                   | Director   |                 | 214-72-8692 <sup>1</sup> Usual Residence of Decedent  | □м 2Х г   | 53                                       | Yrs.                      | Months                               | Days                  | Hours Min.                                      | OCE T 27                              | , rear/9              | 56   Mar                                      | y Land  |
|                   | /land<br>f show<br>ed at   | tor             | 10a. State 10b. County  |   | 10c. City, To                            |                           |                                      |                       |   |                                       |                       |   | 10d. Inside City Limits                           |
|                   | or 28a-<br>notifie   | Director        | Maryland N/A  10e. Street and Number  |   | В  | alti                      | more                                 | Code                  | -   |                                       | 10a Cit               | izen of What Co                               | 1 X Yes 2 □ No                                    |
|                   | s 23a c  | Funeral         | 1900 Braddish Ave   | nue   |  |                           |                                      | 2121                  | L6  |                                       | US                    |   | unu y :   |
| 980               | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   | þ               | 11. Marital Status<br>1 ※ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decedent Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates.      |  | 11                        | Vas Decede<br>Yes, specif            | y Cuban, I            | anic Origin? (Sp<br>Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)      |                       | 14. Race - Ame<br>Black, White<br>Specify: BI | e, etc.   |
| 21215-0036        | hin 72 hour<br>ne.<br>than "natu<br>e Medical  | Completed       | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Seconday (0-12)  |   |  | (Give k<br>life. DC       | NOT use r                            | done duri<br>retired) | on<br>ing most of work                          | ing                                   | 16b. Ki               | nd of Business                                |   |
|                   | Hygie<br>other<br>ent, th  | Be C            | 17. Father's Name (First, Middle, Last)   | 3   |  | A                         | ccoun                                | <u> </u>              | 8. Mother's Nam                                 | ne (First, Middle,                    | Maiden S              | Bankin<br>Surname)                            | 8   |
| ylan              | 2 should be filed within<br>th and Mental Hygiene.<br>27 is marked other tha<br>traumatic event, the N   | 은               | Oliver Owens  |   |  |                           |                                      |                       | Kather  | ine M.                                | John                  | son   |   |
| Maryland          | 2 shou<br>Ith and<br>27 is m<br>traum  |                 | 19a. Informant's Name/Relationship (7)  Jessica Dubard,   |   |  |                           |                                      |                       | Number or Run<br>Avenue E                       |                                       |                       |   |   |
|                   | e 1 and<br>of Heal<br>of Heal<br>if item ?   |                 | 20a. Method of Disposition  1  Burial 2 Cremation 3   |   | 20b. Place                               | of Dispos                 | sition (Name<br>natory or oth        | e of                  |   | Date                                  |                       | ocation - City or                             |   |
| Baltimore,        | nit. Page artment o ortant: If injury or   |                 | 4 Donation 5 Other (Speci   | ý)  | Metro                                    |                           |                                      |                       | 04/2  |                                       |                       |   | , Maryland  |
| Ba                | permit. Departr Importa any inju   |                 | 21. Signature of Funeral Service Licens   | Thomas (  | regor                                    | 1 C                       | remat.<br>99 Fre                     | ion<br>ederi          | Society<br>ick Road                             | Of Mary<br>Baltim                     | 1and ore,             | , Inc.<br>Maryla                              | nd 21228  |
| -1                | Physician/   |                 | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)    |   |  | not ente                  | r the mode                           | of dying, s           | such as cardiac                                 | or respiratory arr                    | rest,                 |   | Approximate Interval Between Onset and Death DAUS |
|                   | Examiner   | _               | Sequentially list conditions  | b. NON-   | SMALL                                    | - <i>CE</i>               | -u i                                 | un                    | ORON.   | G-R                                   |                       |   | MAY 2009  |
|                   | be executed<br>sician and<br>burial-transit  | l Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last | Due to (or as   | a consequence                            | e of):                    |                                      |                       |   |                                       |                       |   |   |
| 200               | physici<br>the bu  | edical          |   | d   |  |                           |                                      |                       |   |                                       |                       |   |   |
| . Box 68760       | the Hospital or Attending Physician: The law requires that the death certificate be executed hint. At hours after death.  the Funeral after death.  the Funeral Director, After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown   | 23c. If yes, outcome 1  Live Birth 4  Pregnant a                          | 2 Fetal dea                              |                           | Ectopic pro<br>Other (spec           |                       |   |                                       | 1                     | 23d. Date of del<br>Month                     | ivery<br>Day Year                                 |
| P.O.              | that th  | by Ph           | Part II. Other significant conditions of  | ontributing to death b  | ut not resulting                         | g in the ur               | nderlying ca                         | ause given            | in Part I.                                      |                                       |                       |   | the cause of death?                               |
| rds,              | requires to<br>been signi<br>should be   | eted            |   |   |  |                           |                                      |                       |   |                                       |                       |   | robably 4 Unknown                                 |
| of Vital Records, | he law i<br>te has b   | Completed       |   |   |  |                           |                                      |                       | <del></del>                                     | 24a. Was autop<br>perfo<br>1 \sum Yes | sy<br>rmed?           | prior to death?                               | topsy findings available completion of cause of   |
| talF              | sician: The la<br>certificate ha<br>irector, page?   | Be              | 25. Was case referred to medical examiner?  | Hospital:   |  |                           |                                      | Other:                | e of Death (Chec                                | k only one)                           |                       |   |   |
| of Vi             | g Physi<br>er this c<br>neral dir  | te: To          | 1 Yes 2 No 27. Manner of Death  | 1 ☐ Inpati<br>28a. Date of inju<br>(Month, Date                           | ent 2 ER/0                               | Outpatien  Time of injury |                                      | c. Injury at          | 4 Nursing Ho                                    | ome 5 Resid                           |                       | •   | ity) HOSPICE                                      |
| sion              | ttendin<br>death.<br>stor: Aft<br>the fur  | Certificate:    | 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be   | )   |  |                           | M st. factory                        |                       | s 2 🗆 No  | 001                                   |                       |   | A Devite Alicenter                                |
| Division          | tal or A   |                 | 4 Homicide determined   | 28e. Place of Injubulding, etc  |  | rarm, stre                | et, ractory, o                       | office                |   | City or Tow                           |                       | l Number or Hui                               | ral Route Number,                                 |
|                   | To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director, After this completed filled in by the funeral di  | Medical         | (Check 2 Medical Exam   | sician: To the best of<br>ner: On the basis of e<br>se Practioner: To the | xamination and                           | or investi                | gation, in my                        | y opinion, o          | death occurred a                                | t the time, date a                    | nd place,             | and due to the                                | cause(s) and manner stated.                       |
|                   | Vithi<br>Volume  |                 | 29b. Signature and title of certifier   | >>7   |  |                           |                                      | License nu            | _   |                                       |                       | e signed (Month                               |   |
|                   | 1/   |                 | 30. Name and address of person who  | completed cause of d  |  |                           | rint)                                |                       | 4395  |                                       |                       |   | 2,2010  |
|                   | I V  |                 | OANIEUE DOBE<br>31. Date filed (Month, Day, Year)   | RMAN, M   | 10 67<br>g's Signature                   | 201                       | NCH                                  | ARL                   | ES STI  | SUITE                                 | 4105                  | BALTIN  | MOREIMO 21204                                     |
|                   | Sta<br>Registra  |                 | ADD 9 9   | 2010  | o orginature                             | 1                         | harle                                | A                     |   |                                       |                       |   |   |

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Lettie May O'Neil 6:35 A. ™ <u>April</u> 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 218 Magnolia Avenue Severna Park 5. Social Security Number 7. Age (In yrs. last birthday) 82 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 F Hours 220 24 5171 North Carolina Director 06/25/1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Severna Park 1 ☐Yes 2X No Directo |Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 218 Magnolia Avenue U.S.A. 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Ş Q Specify: White 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than' Elementary/Secondary (0-12) 12th College (1-4or 5+) Record Researcher Social Security Adm. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Cummings Carrie L. Baker ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 is Injury or other trau Gary O'Neil / Son 315 Seward Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 04/23/2010 | Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 manueleule 23a. Par 1. Enter the disease, complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCLERMIC CARDOVASCULAR /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c, If ves, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Dav 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 10 No 2 🗆 No 1 Tyes 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10 V

Baltimore, Maryland 21215-0036

Box 68760,

۵.

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

DD 2 0 2010

Alle



141)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D21776

APRIC 20, 2010

MIGHWAY, MSADENA MD 21122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Time of Death Month 2 Physician/ Asa Lavane Peterson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Ye 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 🕅 M 2 🗆 F Days Country) 76 Months Hours 215-32-2783 Director Maryland 4. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville MD 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 8111 Old Harford Road U.SA. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. ğ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Gaines and Company Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Operator 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Asa Russell Peterson Mary Emma Howard injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Arlene Peterson/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8111 Old Harford Road, Parkville, Maryland 21234 permit. Page 1 and 2 sl Department of Health ar Important: If item 27 is any injury or other tra. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 20, Evans Funeral Air Chapel - Bel Air 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland 2010 Signature of Funeral Service Licenses 22 Name and Address of Facility Evans Funeral 8800 Harford I 1 Chapel & Cremation Services Road, Parkville, Maryland 21234 2 a. P rt1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Atheroscherotic coronary vascular Disease Onset and Death diate Cause (Final Physician/ timase or condition Medical resulting in death) **Examiner** Abdominal antic anemy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of), Exami pertensi To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical 0 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Year Month Day Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Jas autopsy certificate ha death? 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be director Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 FR/Outpatient 3 DOA မ 1 Yes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 - Certifying Nurse Franticion To the Sent of my knowledge 29b. Signature and title of certifie M D0062735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd. Baltmore, MD 21239 Aparna Jonnal MD 31. Date filed (Month Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Kathleen R. Reaves 04 2010 2:45a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Genesis Health Care Collegeview Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 6. Sex Age (In yrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) 1 M 2 XF Director 218-46-6099 61 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie MD Anne Arundel 1 🗆 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>7525 Baleen Ct</u> 21061 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 1 Never Married 2 X Married β 1 Yes 2 Baltimore, Maryland 21215-0036 2X No 1 ☐ Yes 2 XNo Specify: Specify: Black 3 
Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> 4yrs Employment Interviewer State Of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ <u>Lena A. Nichols</u> Howard H. Reason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> William Reaves-Husband</u> Baleen Ct. Glen Burnie, Md 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/24/2010 On-Site Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av 21215 Baltimore, Md Ave Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on ioations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sig 7, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera

Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and the new state of my knowledge, death occurred at the time, date and place, and the new state of the cause(s) and harmone stated. 29b. Sit itle of certifier 2006 2223 dress of person who completed cause of death (Item 23a) (Type, Print) O LALLY M DUVE SUITE #135 MD) 661 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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|---|---|-------------|---|--------|---|---|---|--|
|   |   |             |   |        |   |   |   |  |

|  |                | 1- For State<br>Registrar   |   | Certi                                 | ficate of        | Death                                 | a montar                                       | , 5.00                            | Reg. N              | 0.  | / I has O has O                               |
|--|----------------|---|---|---------------------------------------|------------------|---------------------------------------|--|-----------------------------------|---------------------|---|---|
| Physic<br>Medical Exam   |                | Decedent's Name (First, Middle, I     Thomas L                                | . Roundtr   | ee. J                                 | r.               |                                       |  | 2. Date of Do                     | eath<br>Day         | / Year                                    | 3. Time of Death<br>2235 hrs                  |
|  |                | 4a. Facility Name (if not institution,  |   | ·                                     |                  | b. City, Town, o                      | or Location of De                              | April 16,                         |                     | 4c. County of Deat                        |   |
|  |                | 1814 Edmondson Aven   |   |                                       |                  | Baltimore                             |  |                                   |                     |   |   |
| Funeral<br>Director  |                | 212-40-3612   | -3612 <sub>1x M 2 F</sub> 68 <sub>Yrs.</sub> Months Days Hours Min. Dec.13,1941 Foreicc |                                       |                  |                                       |  |                                   |                     | rthplace (State or<br>gn<br>puntry) D     |   |
| any  |                | Usual Residence of Decedent  10a. State 10b. County                           |   | 10c. City, To                         | wn or Locatio    | n                                     |  |                                   |                     |   | 10d. Inside City Limits                       |
| *  | ř              | MD n/a  |   | Bal                                   | timor            | е                                     |  |                                   |                     |   | 1 Yes 2 No                                    |
| Maryland<br>28a-f sho  | Director       | 10e. Street and Number  |   |                                       |                  | 10f. Zip Code                         |  |                                   | 10g. C              | itizen of What Cou                        | ntry?   |
| hours after death with the Maryland<br>natural", or items 23a or 28a-f she<br>Examiner must be notified at once  |                | 1814 Edmonds  |   | Apt.l                                 |                  | 2122                                  |  |                                   |                     | USA                                       |   |
| eath wi  | uneral         | 11. Marital Status 1 Never Married 2 Marri                                    | 12. Was Decedent<br>Armed Forces?   |                                       |                  |                                       | lispanic Origin? (<br>an, <b>M</b> exican, Pue | Specify Yes or Norto Rican, etc.) | 10-                 | 14. Race - Amer<br>White, etc.            | ican Indian, Black,                           |
| after de<br>al", or  | by Fu          | 3 Widowed 4 Divorce   | 1 Yes 2 ed If Yes, Give Year or Dates:  | X No                                  | 1 \              | res 2 N                               | o specify:                                     |                                   |                     | Specify Blac                              | ck  |
| hours.<br>natur  |                | 15. Decedent's Education (Specify   | only highest grade com  |                                       |                  |                                       | ation (Give kind of                            |                                   | 16b.                | Kind of Business/                         | Industry                                      |
| 0036 within 72 giene. her than "   | Completed      | Elementary/Secondary (0-12) unknown   | College (1-4 or 5   | i+)                                   | labo             | _                                     |  | ,                                 | Be                  | thlehem                                   | Steel Co                                      |
| 5-0036<br>led within 72<br>Hygiene.<br>other than '  |                | 17. Father's Name (First, Middle, La  | •   |                                       |                  |                                       | 18.Mother's Na                                 | me (First, Middle                 |                     |   |   |
| 21215-003 and be filed within Mental Hygiene, marked other tl  | o Be           | Thomas L. Ro  |   |                                       | 40h M. W         |                                       |  | atheri                            |                     |   |   |
| sho and 7 is   | То             | Karen Loney (   |   |                                       |                  |                                       |  |                                   |                     | City or Town, State                       |   |
| 2 78 28 78 1   |                | 20a. Method of Disposition  1 🔀 Burial 2 Cremation                            | 3 D B   | 20b. Plac                             | e of Dispositi   | on (Name of ce                        | emetery,                                       | Date                              |                     | Location - City or                        |   |
| Baltimore,<br>permit. Pages I a<br>Department of He<br>Important: If ite   |                | 4 Other Spec  | ify:  | Mt.                                   | Zion (           | Cemete                                | ery Ap   | r.26,2                            | 010                 | Balto                                     | ,Md.  |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or oth  |                | 21 Jature of Funeral Service Lic  | 7/16  |                                       | <sup>22</sup> Na | Tvin E                                | s of Facility<br>SCru                          | ggs Fu                            | ner                 | al Home                                   |   |
| Physician  | _              | 23a. Part I. Enter the disease, or con  | implications that caused  | the death. Do                         | not enter the    | mode of dying                         | Presto   | n St.                             | Ball<br>rest, sh    | to, Md                                    | 21213<br>Approximate Interval                 |
| /Medical<br>Examiner   |                | failure. List only one cause on   | each line.<br><sub>a.</sub> Atherosclerotic (   | , ,                                   |                  |                                       |  |                                   |                     |   | Between Onset and<br>Death                    |
| LAdiiiilei   |                | or condition resulting in death)  | Due to (or as a conse   | quence of):                           |                  |                                       | -  | -                                 |                     |   |   |
|  | Ē              | if any, leading to immediate  | b.<br>Due to (or as a conse   | quence of):                           |                  |                                       |  |                                   |                     |   |   |
|  | Examiner       | (Disease or injury that initiated events resulting in death) Last             | c.<br>Due to (or as a conse   | quence of):                           |                  | _                                     |  |                                   | _                   |   |   |
| 760,<br>cate be executed<br>physician and<br>the burial - transit  | I              |   | d   | · · · · · · · · · · · · · · · · · · · |                  |                                       |  |                                   |                     |   |   |
| 760,<br>cate be executed<br>physician and<br>he burial - transi  | Medical        | UNPENDED  | AMENDED   |                                       |                  |                                       |  |                                   |                     |   |   |
| 18760,<br>rtificate be<br>ing physic<br>as the buri  |                | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?            | 23c. If yes, outcom   | e of pregnand                         | . —              | death 3                               | Ectopic preg                                   | nancy                             | 23                  | id. Date of delivery  Month  D            | ay Year                                       |
| Box 68 <sup>-</sup> s death certifi the attending ed for use as 1  | Physician/     | 1 Yes 2 No 9 Unknow   | 4 Pregnant at t   | ime of death                          | - =              | (Specify)                             |  |                                   | 1                   |   | •   |
| O. B. at the de ached f  |                | Part II. Other significant conditions   |   | but not result                        | ting in the und  | lerlying cause                        | given in Part I.                               | 23e. Did t                        | obacco              | use contribute to t                       | he cause of death?                            |
| ires that the signed by  | d b            |   |   |                                       |                  |                                       | ·  | 1 Ye                              | s 2 🔽               | No 3 Prob                                 | ably 4 Unknown                                |
| Records,  The law require fificate has been si   | Completed      |   |   |                                       |                  |                                       |  | 24a. Was<br>auto                  | psy                 |   | opsy findings available ompletion of cause of |
| Rec<br>The la<br>icate h   | E S            |   |   |                                       |                  |                                       |  | 1 ✓ Yes                           | ormed?<br>2 N       | death?<br>lo 1 ✓ Ye                       | s 2 No  |
| ital Residuals The scertificate rector, page   | å              | 25. Was case referred to medical examiner?                                    | Hospital: 1 Inpatien  | 4 2 TER                               | Outpatient 3     |                                       | Other Nurs                                     |                                   |                     |   |   |
| of Vital<br>ing Physician<br>After this certi<br>uneral director   | 입              | 1 Yes 2 No<br>27. Manner of Death   | 28a. Date of Injun  | / 281                                 | outpatient 3     |                                       | ry at Work?                                    | ing Home 5 28d. Describe          |                     | ence 6 🗸 Other:                           | Scene   |
| ion<br>ttendin<br>leath.<br>tor: A   | atior          | 1 Natural 5 Pending 2 Accident Investiga                                      | (Month, Day, Ye   | ar)                                   |                  | 1`                                    | Yes 2 No                                       |                                   |                     |   |   |
| Division all or Attendius after death.  al Director: A   | Certification: | 3 Suicide 6 Could no determin   | at be 28e. Place of Inju  | ıry - At home,                        | farm, street,    | factory, office b                     | ouilding, etc.                                 | 28f. Location (<br>or Town, 5     |                     | and Number or Rur                         | al Route Number, City                         |
| fospita 4 hours uneral   |                | 4 Homicide  | (0,000,1))  | knowlodgo d                           | loath occurred   | Lat the time de                       | ate and place                                  |                                   |                     |   |   |
| Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the complete of the control of the co | Medical        | (Check only one) 2 Medical Examin   | cian: To the best of my<br>er:On the basis of exam<br>and manner stated.                | ination and/o                         | r investigation  | i at the time, da<br>i, in my opinion | ate and place, ar<br>i, death occurred         | at the time, date                 | se(s) an<br>and pla | id manner as state<br>ace, and due to the | d.<br>cause(s)                                |
| F % F 3  | Me             | 29b. Signature and title of certifier   | and manner stated.  |                                       |                  | 29c. Licens                           |  |                                   | 29d. I              | Date signed (Mon                          | th, Day, Year)                                |
|  |                | Mayout Ime  | Mull  |                                       |                  | O.C.I                                 | M.E.   |                                   | Apri                | il 17, 2010                               |   |
|  |                | <ol> <li>Name and address of person who<br/>Margarita Korell MD. A</li> </ol> | completed cause of deases sistant Medical E   |                                       |                  | n Street, B                           | altimore, MD                                   | 21201                             |                     |   |   |
|  |                | 31. Date filed (Month, Day, Year)   | 32. Registrar's   | Signature                             |                  | Kal                                   |  |                                   |                     | •   |   |
| Regist   | rar            | APR 2 2   | 2010 Clever   | w p                                   | . 7              |                                       |  |                                   |                     |   |   |

| 10-02968     |         |
|--------------|---------|
| Audrey Lee I | Randell |

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| 2 | 0 | - | 0 | er-system | 2 | 5   | 2 |
|---|---|---|---|-----------|---|-----|---|
|   |   |   |   |           |   | -40 | _ |

| ,   |                | 1- For State Certificate Registrar   | ate of Death  | Reg. No.                     | ).  | 1 200  |
|---|----------------|--|---|------------------------------|---|--|
| Physicia<br>Medical Examir  | n/             | Decedent's Name (First, Middle, Last)     Audrey Lee Randell   | 2. Date of<br>Month<br>April 1  | f Death<br>Day<br>16, 2010   | Voor  | Time of Death                                    |
|   |                | 4a. Facility Name (if not institution, give street and number) 4602 Springwater Court #B   | 4b. City, Town, or Location of Death Owings Mills   |                              | c. County of Death<br>Baltimore County                            |  |
| Funeral<br>Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birt 480-48-1930 1 M 2XF 66  |   | of Birth(MM<br>31/4          | 3 Poreign N<br>Country  | 10   |
| te Maryland<br>or 28a-f show any<br>f <u>ied at once.</u>   | or             | Usual Residence of Decedent  10a. State  | s Mills   |                              | 1 [   | t. Inside City Limits Yes 2 No                   |
| the Maryl   | Direct         | 10e. Street and Number 4602 Springwater Court  | 10f. Zip Code 21117   |                              | tizen of What Country?<br>JSA                                     |  |
| ufter death with<br>11", or items 2:<br>ner must be n   | by Funeral     | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Yes 2 No 12 Yes 2 No 13 Widowed 4 Divorced or Dates:  | 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc)  1 Yes 2 X No specify: |                              | 14. Race - American I<br>White, etc.<br>African<br>Specify:Americ | , ,  |
| 6<br>172 hour<br>an "natu   | Completed b    | 15. Decedent's Education (Specify only highest grade completed)  16a.  | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) gislative Liaison Dir  |                              | Kind of Business/Indus  | •  |
| 215-0036<br>be filed within 7<br>ntral Hygiene.<br>Rked ofher than<br>ent, the Medica   | Be Cor         | 17. Father's Name (First, Middle, Last) Cecil E. Randell   | 18.Mother's Name (First, Mic  | outh-                        | - Portia L.   |  |
| MD 21 nd 2 should ' ulth and Me m 27 is man aumatic ev  | <u>٩</u>       | 4  | 5. Mailing Address (Street and Number or Rural Route<br>510 Basswood Rd, Minne  |                              |   |  |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Medi |                | 1 Burial 2 Cremation 3 Removal from State Oakda  | of Disposition (Name of cemetery, ory or other place) alle Mem. Gard.  6/5/10   | 0-Dav                        | Location - City or Town<br>venport, I                             | A  |
| Balti permit. Departm Imports injury o  |                | 21. Signature of Funeral Service Livensee  | 22. Name and Address of Facility Hari P<br>5126 Belair Rd, Balt   |                              |   |  |
| Physician<br>/Medical<br>Examiner   |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive athe | ot enter the mode of dying, such as cardiac or respirator erosclerotic cardiovascul   |                              | B   | oproximate Interval<br>etween Onset and<br>Death |
|   | iner           | Sequentially list conditions, if any, leading to immediate  b  |   |                              |   |  |
| ed<br>nsit  | Examine        | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |                              |   |  |
| 760,<br>icate be executed<br>physician and<br>the burial - transit  | edical         | X UNPENDED AMENDED 20b per fh<br>23a,27,per  | <b>g903 5-10-10 vt 18 per f</b><br>ME G904 6/21/10 TT   | h g90                        | 3 5–13–10v  | t  |
| O. Box 68760, that the death certificate be red by the attending physici detached for use as the burn   | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 9 Unknown                                      |   | _                            | 3d. Date of delivery  Month Day                                   | Year   |
| ires that the de signed by the leed etached f   | by Ph          |  |   |                              | o use contribute to the c   |  |
| cords law requ  | Completed      |  |   | Was an autopsy performed?    |   | y findings available letion of cause of          |
| tal Recian: The certificate ector, page   | Bec            | 25. Was case referred to medical examiner?   | 26.Place of Death (Check only one)  |                              |   |  |
| f Vit   | 의              | 1 Yes 2 No Inpatient 2 ER/O  | utpatient 3 DOA Other Nursing Home  |                              | ence 6 🗹 Other: Sce<br>jury occurred                              | ne   |
| on of \ ending Ph; ath. or: After tl  | ţi.            | 1 X Natural 5 Pending (Month, Day,Year)  | 1 Yes 2 No  |                              | ,,  |  |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, fa   |   | tion (Street a<br>wn, State) | and Number or Rural R   | oute Number, City                                |
| To the Hospital within 24 hours To the Funeral completely filled  | Medical (      | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea (check only one)  Medical Examiner: On the basis of examination and/or in  |   |                              |   | use(s)   |
| To To   | ě l            | 29b. Signature and title of certifier  | 29c. License number   | 29d.                         | Date signed (Month, L   | Day, Year)                                       |
| 2 obserd  |                | 30. Name and address of persor who impleted cause of death (fem 23a)   | O.C.M.E.  |                              | ril 17, 2010  |  |
| 7-11  |                | Theodore M. King, Jr., MD. Assistant Medical Exam  | iner 111 Penn Street, Baltimore, MD 2   | 1201                         |   |  |
| Sta<br>Registi  |                | 31. Date filed (Month, Day, Year) 32. Begistrar's Signature  | to a dad  |                              |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g902,04722/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Apri Physician/ Day Meta J. Stahler 2010 9:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 817 South Camp Meade Road Linthicum If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
June 9, 1959 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours Marviand 217-74-0841 50 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov amy injury or other traumatic event, the Medical Examiner must be notified at once. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 🛱 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21122 163 Waldo Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise T. Risso Walter E. Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 School Avenue #105 Excelsior, MN 55331 Jill Stahler, Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/05/10 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Chematiums 55cmety Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor roma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxia/Anoxia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner failune respirator dio Sequentially list conditions, if any, leading to manage cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical small 411 MM Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Vear Day Pregnant at time of death signed by the a d be detached for ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ain 24 hours after death.

the Funeral Director: After this certificate has been significate filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ XOther (Specify) HOSDICE 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, 2 68975 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MD 21231 Hatim Husain 1650 Orleans Street Baltimore, 31. Date filed (Month, Day, Year) gistrar's Signature State APR 2 2 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April Indar S. Schabra 2010 3:05 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Genesis Eldercare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Oct. 18, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pakistan 1 X M 2 □ F 67 1942 Director 415–76–6723 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show t be notified at 1 ☐ Yes 2 X No Columbia Director Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21044 10001 Windstream Drive ns 23a must b Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items "natural", or item edical Examiner Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Asian Indian 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event, the Medione. College (1-4or 5+) Elementary/Secondary (0-12) NOAA 5+ Real Estate Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harbans Kaur Sajjan Singh Chhabra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 4714 Middle Court Ellicott City, Maryland 21043 Lita S. Parke, Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory, Inc. 04/25/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee Alice Iser 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Cell corring of the lune Squamous **Physician** Metustanic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed Due to (or as a consequence of): burial-P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year ρį in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page performe 1□ Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? funeral director, 26. Place of Death Check onl one Be Other: Hospital: y Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P47683 Waymend Milli Mis 20/10

12V

State Registrar Maymay Millie 2835 Snith Ave Soute 203 31 Date filed (Month, Day, Year) -- 32. Replacar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 22 2010 Seems D. Jane

Balhmore

**ORIGINAL** 

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 03:20 AM IDNEY STOLLE NGS APRIL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL (ENTER MORE Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Min 10-27-19 87 West **Director** 236-24-3584 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 28a-f MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1024 S. Decker Avenue 21224 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Yes 2 No Army Yes, Give ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", Specify: Completed 3 Widowed 4 Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. d other than \* Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Heater A 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Samuel Sidney Stollings Girtie May Miller permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 Rockleigh Dr. Arbutus, MD 21227 Ronnie Stallings 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4/26/2010 Crownsville, MD Crownsville Va. 4 Donation 5 Other (Specify) 21. Signature of al Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. FH 1 263 S. Conkling St.Baltimore,MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure, List only one cause on each line Immediate Cause (Final Onset and Death Frysician/ 0515 disease or condition resulting in death) 0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or impry] Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year been signed by the should be detached g Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s or this certificate has eral director, page 2 autopsy performed? Yes 2 No death? : After this certifications and director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis or examination and/or investigation, in this opinion, details and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE GOVIL M.D. 4940 AVENUE 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APRIDay Physician/ 11:30 M Medical Name (if not institution, give street and number Town, or Location of Death **Examiner** 4c. County of Death timore ast birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** th Pay Ye Country) Yrs. Director or items 23a or 28a-f show 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 No
12. Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 0 Specify: "natural" 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT upgratired) (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Be 17. Father 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If Item 27 is marked of any injury or other traumatic ever once. မ Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City own, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signal e of Funeral service Livensee MO/55 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (ex as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequent that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 2 9 Unknown 9 Unknown Ö been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 4 Unknown 2 🗌 No Records, 1 🗌 Yes 3 Probably Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Director: After this certificate 2 No Yes Division of Vital B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2  $\square$  No 은 1 Inpatient 2 i ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 🗆 Yes 5 Pending 2 No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) thin 24 hours a...

o the Funeral Dir. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier 2010 20 Name and address of person who completed of death (Item 23a) (Type, Print) 540 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician Month Year -ond al 20/6 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner inst J.SU timer 40 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Months Days Hours **1** M 2 □ F 80 Director 10 24 218-22-2052 MD Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f sho Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3222 Ingleside Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any Injury or other traumatic event, the Westernessonce. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp 12th grade Steel Worker 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Strong ပ Genevieve Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3222 Ingleside Ave, Baltimore, Md 21215</u> <u>Brenda Strong-Wife</u> 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 4/28/2010 Owings Mills, Md 21. Signature of F March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 D Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate h performed? 1 □ Yes 2 No 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide n 24 hours af e Funeral Di etely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the the within To the 29b. Signajure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) USICIAN 1157543 Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDHU ST. BALTIMORE MD 2/223 1940 W. BALTIMORE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:10 AM 2010 Stevenson WYI Pearl /Medical Lillie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Baltimore Hospita If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Jumber 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Yrs Director 18 TN 412-38-5761 Usual Residence of Decedent 84 filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at 1 ☐Yes 2 ☐ No Director Baltimore MD NA 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21229 U.S.A. 27 South Bernice Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify Black Be Completed by 3√2 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Importants if item 27 is marked other the any injury or other traumatic event, the Jonee. 2th grade Food Services Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Beasley Joseph Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4935 Todd Ave Apt B, Baltimore, Md 21206 Charrice Stevenson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 4/24/2010 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Physician yrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecutants off Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has filled in by the funeral director, page 2 autopsy certificate 2 No 1 □ Yes Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person high completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year APR 2 State Registrar

DHMH 17 Rev 1/2001

SKVENSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Trem 23b per doc g902 4-22-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010<sup>Year</sup> Amonth Marian L. Schueler 12:01 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3109 Orchard Avenue Baltimore Parkville Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13, 1952 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 😾 F Months Hours Maryland 58 212-50-2587 Director Usual Residence of Decedent if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Parkville MD Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 3109 Orchard Avenue U.S.A. 21234 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White Completed 3 - Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Local 16 Elementary/Seconday (0-12) College (1-4 or 5+) Iron Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leo Rydzewski Jean Jeffrey 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
100 Ocean Drive, Ocean City, MD 21842 19a. Informant's Name/Relationship (Type, Print) Dale Cassedy/ Sister April 19, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Evans Funeral Chapel – Bel Air 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 2010 Lunature of Funeral Service Licenses <sup>22 Name and Address of Facility</sup> Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. erval Retween Onset and Death homediate Cause (Final Obstruction Physician disease or condition resulting in death) ronic Medical Due to (or as a consequence of): 33 Examiner Ma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been sinned by the control of the cont P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for the funeral director. 9 Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16801

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 9103

Franklin Jacobs Dr. Balto Mid 21257

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILLI A M
31. Date filed (Month, Day, Year)

10-03100 Charles Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 12529

|   |               | - For State  | Certificate d                                 | of Death                   |                              | -                            | Reg                          | . No.                                   |   |
|---|---------------|--|---|----------------------------|------------------------------|------------------------------|------------------------------|---|---|
| Physicia  |               | Registrar  1. Decedent's Name (First, Middle,Last)   |   |                            |                              |                              | ate of Death                 | Day Year                                | 3. Time of Death  |
| edical Exami  |               | Charles C. Smith   |   |                            |                              | Ap                           | oril 20, 20                  | 10                                      | 2137 hrs  |
|   |               | 4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center   |   | 4b. City, Town, o          | r Location o                 | f Death                      |                              | 4c. County of D<br>Harford              | eath  |
| Funeral   |               |  | In yrs. last birthday)                        | If Under 1 Ye              |                              | r 24Hrs. 8. I                | Date of Birth                | (MM/DD/YYYY) S                          | Birthplace (State or oreign Mary Land                       |
| Director  |               | 215-30-3369 <sub>1XM 2F</sub>  | 76 <sub>Y</sub>                               | rs. Months Da              | ys Hours                     | Min. F                       | eb. 13,                      | 1934                                    | Country)  |
| ķ   | -             | Usual Residence of Decedent  10a, State 10b, County 10   | Oc. City. Town or Loc                         | ation                      |                              |                              |                              |   | 10d. Inside City Limits                                     |
| Maryland<br>28a-f show any<br>datonce.  |               | MD ISSUED  | Balti   |                            |                              |                              |                              |   | 1 X Yes 2 No  |
| urylane<br>Sa-f st  | Director      | 10e, Street and Number   |   | 10f. Zip Code              |                              |                              | 100                          | . Citizen of What                       | Country?  |
| with the Maryland<br>ms 23a or 28a-f sho<br>be notified at once.  | ä             | 4729 Hazelwood Avenue  |   | 21                         | 206                          |                              |                              | U.S.A.                                  |   |
| n with<br>ms 23<br>be no  | era           | 11. Marital Status 12. Was Decedent Ev   | er in U.S. 13. V                              | Vas Decedent of H          | ispanic Orig<br>an, Mexican, | in? ( Specify<br>Puerto Rica | Yes or No-<br>n, etc.)       | 14. Race - A<br>White, e                | American Indian, Black,<br>etc.                             |
| r death   | Funeral       | 1 Never Married 2 Married 1 X Yes 2  | No  | Yes 2. N                   |                              |                              |                              | Specify:                                | White   |
| rs afte<br>ural",   | ē             | 3 Widowed 4 Divorced If Yes, Give Year KOX  15. Decedent's Education (Specify only highest grade complete)   |   | ent's Usual Occup          |                              | kind of work o               | done                         | 16b. Kind of Busin                      | ess/Industry  |
| 5-0036 led within 72 hours : Hygiene, other than "natur: the Medical Exami  | Completed     | Elementary/Secondary (0-12) College (1-4 or 5+)  | during  | most of working lift ailor | e. DO NOT                    | use retired)                 |                              | Grue Ta                                 | ilors   |
| 036<br>vithin 7;<br>ene.<br>er than   | E E           | 12   |   | 41101                      | 40.84-45-4                   | la Nama (Fina                | A Adidata Ada                | aiden Surname)                          |   |
| 15-0<br>filed v<br>Il Hygi<br>ed oth<br>t, the l  |               | 17. Father's Name (First, Middle, Last)  Robert L. Smith   |   |                            |                              | Helen                        |                              |   |   |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mould Hygiene Health and Mould Hygiene fiten 27 is marked other than "natural", or items 23a or 28a-f she re traumatic event, the Medical Examiner must be notified at once   | o Be          | 19a. Informant's Name/Relationship (Type, Print )  | 19b. Mail                                     | ing Address (Stre          | et and Num                   | ber or Rural                 | Route Numb                   | er, City or Town,                       | State, Zip Code) 21206                                      |
| and 2 shou cealth and N   |               | Stephanie Feathers/Daug  |   | 9 Hazel                    |                              |                              | ·                            | 20c. Location - Ci                      |   |
| 10re,<br>ages l and<br>nt of Heal<br>t: If iten   |               | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  | 20b. Place of Disp<br>crematory or<br>Cardens |                            | emetery,<br>th               | April                        | 24,                          |   | , Maryland  |
| Baltimore, permit. Pages I an Department of Hea Important: If itelinjury or other tr  |               | 4 Donation 5 Other Specify:  | Cemete  | Nome and Addre             | se of Eacility               | 2010                         | )                            |   |   |
| Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.   |               | 21. lignature of Funeral Service Licensee  | )   [1]                                       | Evans Fi<br>3800 Hai       | inera<br>rford               | l Cha<br>Road                | ipel & C<br>I, Parkv         | remation<br>ville, Mar                  | Services<br>cyland 21234                                    |
| Physician   | 1             | 2 al. Part I. Enfer the disease, or complications that caused the failure. List only one cause on each line.   | e death. Do not ente                          | r the mode of dyin         | g, such as ca                | ardiac or resp               | piratory arres               | st, shock, or heart                     | Approximate Interval<br>Between Onset and                   |
| Vedical<br>Examiner   |               | Immediate Cause (Final disease a. Hypertensive Athe  | erosclerotic Car                              | diovascular D              | isease                       |                              |                              |   | Death   |
| _xammer   | ~             | or condition resulting in death) Due to (or as a consequ   | uence of):                                    |                            |                              |                              |                              |   |   |
|   | <u>اة</u>     | Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of the conditions)   | uence of):                                    |                            |                              |                              |                              |   |   |
|   | a<br>i        | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d. |   |                            |                              |                              |                              |   |   |
| ecuted<br>and<br>transit  |               |  |   |                            |                              |                              |                              |   |   |
| ex<br>ian   | Medical       | UNPENDED AMENDED   |   |                            |                              |                              |                              |   |   |
| 3760, ficate be g physic s the bur  |               | IF FEMALE: 23c. If yes, outcome 1 Live birth   | -   | Fetal death 3              | Ectopic                      | c pregnancy                  |                              | 23d. Date of de<br>Month                | elivery<br>Day Year   |
| Box 687  e death certific  the attending p  | Physician/    | past 12 months?  |   | Other (Specify)            |                              |                              |                              | 1                                       | 7   |
| D,O, Bo<br>that the dea<br>ned by the a<br>detached fo  | hys           | 1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death by   | out not resulting in th                       | e underlying cause         | e given in Pa                | art I.                       | 23e. Did tob                 | pacco use contribu                      | ute to the cause of death?                                  |
| r, P.O.   | by            | End Stage Renal Disease; Diabetes Mellitu  |   | ,,,,                       |                              |                              | 1 Yes                        | 2 No 3                                  | Probably 4 V Unknown  |
| 'ds,<br>require   | Completed     |  |   |                            |                              |                              | 24a. Was a                   |   | ere autopsy findings available or to completion of cause of |
| COF<br>e law r<br>e has t<br>ge 2 sh  | du            |  |   |                            |                              |                              | perform                      | ned? dea                                | ath?<br>✓ Yes 2 No  |
| Vital Recysician: The his certificate director, page  |               | 25. Was case referred to medical   |   | 26.Pla                     |                              | (Check only                  | one)                         |   |   |
| Vita hysicia hysicia I direct   | To Be         | examiner?  1 Yes 2 No Hospital: 1 Inpatient  | t 2 🗹 ER/Outpatie                             |                            |                              |                              |                              | Residence 6                             |   |
| Division of Vital Records, tal or Attending Physician: The law requir as after cleath.  al Director: After this certificate has been so led in by the fineral director, page 2 should b   |               | 27. Manner of Death 1 ✓ Natural 5 Pending  | 28b. Time o                                   |                            | jury at Work                 | .                            | I. Describe h                | ow injury occurred                      | J   |
| Siol<br>Attence<br>r death<br>ector:<br>by the  | cati          | 2 Accident Investigation 28e. Place of Injul   | ry - At home, farm, st                        |                            |                              |                              | Location (S                  | treet and Number                        | or Rural Route Number, City                                 |
| Divisior Sepital or Attend hours after death nneral Director: y filled in by the  | ertification: | 3 Suicide 6 Could not be determined (Specify)  |   |                            |                              |                              | or Town, St                  | ate)                                    |   |
| Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as the control of the | ၂ပ            | 29a. Certifier 1 Certifying Physician: To the best of my (Check only   | knowledge, death oc                           | curred at the time,        | date and pla                 | ace, and due                 | to the cause<br>time, date a | e(s) and manner a<br>and place, and due | s stated.<br>e to the cause(s)                              |
| To th<br>within<br>To th  | Medical       | 2 Medical Examiner: On the basis of examiner: and manner stated.   |   |                            | nse number                   |                              | 1                            |   | (Month, Day, Year)  |
|   |               | O.C.M.E. April 21, 2010  |   |                            |                              |                              |                              |   | 0   |
|   |               | 30. Name and address of person who completed cause of dea  |   |                            |                              |                              |                              |   |   |
| )   |               | Laron Locke MD. Assistant Medical Exar   | miner 111 Pe                                  | nn Street, Bal             | timore, M                    | ID 21201                     |                              |   |   |
| Regis   | tate          |  | .02   | and the second             |                              |                              |                              |   |   |

DHMH 17 Rev 1/2001

OCME

ORIGINAL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10d, per FH G902 4/22/10 TT

State of Maryland / Department of Health and Mental Hygiene 2 0 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Kenneth G. Szeliga 20 2010 5:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 19 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 DM 2 DF Director 1940 214-40-2566 69 OSIS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Baltimore Baltimore + XI Yes XI No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 by Funeral 1517 Wilson Point Road USA "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates After Specify: White 3 Divorced 55 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Northrup Grumman permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. Mechanical Engineer 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Chester B. Szeliga Audry M. Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Wilson Point Rd., Balto., MD 21220 Mary C. Szeliga – Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Bayview Crematory 4-21-10 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 21. Signat uneral Service Livens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adenocarcinoma ¬Ph sician/ of unknown disease or condition resulting in death) ews Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 2 🗆 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital: 2 💢 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🌠 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Kertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier R149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant 6701 M Charles 10 WSUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Stephen W. Simon 2010 12:14 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Year 1929 1 ፟M 2 □ F Days Hours Min March 2 215-30-8970 Maryland 81 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 🎽 No 10e Street and Number 10f. Zip Code 10q, Citizen of What Country? Funeral 13801 York Road 21030 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 Specify: white 1 ☐ Yes 2 K No Specify. Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Simon 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) professor education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Simon Katharine Warrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1478 Wellington Circle; Rockledge, Florida 32955 Sylvia Eppig/daughter Department of Health Important: If item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 X Donation 5 ☐ Other (Specify) 22 Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Funeral Service Licensee 21. Sign Director Approximate Interval Between Onset and Death 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, er heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Disc to for his is poned wants. B cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔎 o Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 ther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🗌 Yes s after death. Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Skowronski Physician/ April 4:50 2010 Drothy )DM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Charlestown Retirement Center Catonsville If Under 1 Year | If Under 24 Hrs 6. Sex Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours 01/09/1917 93 Director 190-07-9525 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Catonsville Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane Brookside 610 21228 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. á 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNK George Rowic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Dan R. Skowronski (Son) 2912 Andrea Avenue, Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 MBurial 2 Cremation 3 Removal from State 04/19/2010 Glen Burnie, MD Glen Haven Memorial Qonation 5 Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure, List only one cause on each line recumona Immediate Cause (Final Enysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 1 Inpatient 2 I ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 3 (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 0 MC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

|   |                | 1 _ State  | epartment of Health and N<br>Certificate of Death                                  |   | 7010 17004  |
|---|----------------|--|--|---|---|
|   |                | Registrar  1. Decedent's Name (First, Middle, Last)  | Octimicate of Beatif   | 2. Date of Death                            |   |
| Physicia<br>/Medic  |                | Margaret Schmid  | lt   | April                                       | 18 2010 1:30 A.M  |
| Examin  |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   |   | 4c. County of Death                                     |
|   |                | Tate Hospice House   | Linthicum  hday) If Under 1 Year If Under 24 Hrs.                                  | O Data of Blath                             | Anne Arundel  |
| Funeral<br>Director   |                | 212 20 3346  | Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day,<br>10/03/1 | 9. Birthplace (State or Foreign<br>Country)<br>Maryland |
| and w   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  | or Location  |   | 10d. Inside City Limits                                 |
| Maryl   | to             | Maryland Anne Arundel Gler   | Burnie   |   | 1 ☐ Yes 2X No   |
| h the   | Director       | 10e. Street and Number   | 10f. Zip Code  | 10  | g. Citizen of What Country?                             |
| 23a c   |                | 903 Geis Circle  | 21061  |   | U.S.A.  |
| tems  | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | 13. Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)            | 14. Race - American Indian,<br>Black, White, etc.       |
| 72 hours after death with the Maryland natural", or Items 23a or 28a-f show fical Examiner must be notified at  | δ              | 1 □ Never Married 2 □ Married 1 □ Yes 2 【X No If Yes, Give 3 【X Widowed 4 □ Divorced Year or Dates:                                    | 1 ☐ Yes 2基 No Specify:   |   | Specify: White  |
| 72 hours<br>"natural"   | sted           | 15. Decedent's Education 16a. (Specify only highest grade completed)   | Decedent's Usual Occupation (Give kind of work done during most of work            | ring 1                                      | 6b. Kind of Business/Industry                           |
| ithin 7<br>ne.<br>han "r  | Completed      | Elementary/Secondary (0-12) College (1-4or 5+)   | (Give kind of work done during most of work life. DO NOT use retired)              | ing   | Restaurant  |
| lled w<br>Tygiel<br>ther th   | S              | 8th  17. Father's Name (First, Middle, Last)   | Waitress / Cashier   | e (First, Middle, M                         |   |
| d be f<br>ental f<br>ced of   | o Be           | Benjamin Franklin  |  |   | eth Shenton   |
| shoul<br>and M<br>mari  | ပ္             | 19a. Informant's Name/Relationship (Type. Print) 19b.  | Mailing Address (Street and Number or Ru   | ral Route Number,                           | City or Town, State, Zip Code)                          |
| and 2<br>saith a<br>n 27 is<br>er tra   |                |  |  |   | e, Maryland 21061                                       |
| Jes 1 a   |                | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State   | Disposition (Name of<br>y, crematory or other place)                               | Date 2                                      | 0c. Location - City or Town, State                      |
| t. Pag<br>tment<br>tant:<br>ijury   |                | 4□Donation 5♥Other (Specify)Entombment Glen H  |  | 2/2010                                      | Glen Burnie, Maryland                                   |
| permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natur any injury or other traumatic event, the Medical once. |                | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility Go<br>4001 Ritchie Highw                          |   | ral Service, P.A.<br>imore, Mar <u>yland 21225</u>      |
| 15 15 14  |                | 23a. Part 1. Enter the disease, or some cations that caused the death. Do r shock, or heart failure. List only one cause on each line. | ot enter the mode of dying, such as cardiac  | or respiratory arre                         | st, Approximate<br>Interval Between                     |
| Physician   |                | Immediate Cause (Final disease or condition  | structive tulmona  | 17.76                                       | Onset and Death  5+42                                   |
| /Medical<br>Examiner  |                | resulting in death)  Due to (or as a consequence of  | of):   | 1   | 0   |
|   | e              | Securitizing list conditions If any, leading to immediate  b. Due to (or as a consequence of   | of):   |   |   |
| cuted<br>Id<br>ansit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                                    |  |   |   |
| cate be executed physician and the burial-transit   |                | resulting in death) Last Due to (or as a consequence of  | of):   |   |   |
| cate b  | edical         | d  |  |   |   |
|   | /Me            | IF FEMALE: 23c. If yes, outcome of pregnancy   |  |   | 23d, Date of delivery                                   |
| The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as   | sician/M       | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 1 Pregnant at time of death   | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)  |   | Month Day Year  |
| that the de<br>ned by the a   | Physi          | 9 Unknown  |  |   |   |
| w requires that s been signed be should be deta   | by P           | Part II. Other significant conditions contributing to death but not resulting in   | the underlying cause given in Part I.  |   | acco use contribute to the cause of death?              |
| een si  |                | Souche hyphoscoliosis comp   | <u>errosens uins caerly</u>  | 1 □ Ye                                      | s 2 No 3 Probably 4 Unknown                             |
| e law<br>has b  | ompleted       |  |  | 24a. Was an<br>autopsy<br>perform           | prior to completion of cause of                         |
|   | O              |  |  | 1 □ Yes 2                                   | No 1 Yes 2 No   |
| s certi<br>irecto   | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou  | Othor  | th (Check only one                          | nce 6 X Other (Specify) Has Soil e                      |
| Attending Physician: r death. ector: After this certific by the funeral director,   | $\vdash$       | 27. Manner of Death 28a. Date of Injury 28b. 7   | Time of plury at Work?   | 28d. Describe ho                            |   |
| endin<br>ath.<br>or: Aft  | atio           | 2 Accident investigation   | M 1 ☐Yes 2 ☐ No  |   |   |
| or Atte<br>fter de<br>iirecto<br>n by t   | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)                       | rm, street, factory, office  | 28f. Location (Str<br>City or Town          | reet and Number or Rural Route Number,<br>, State)      |
| pital ours a eral D   |                | 29a. Certifier 1X Certifying Physician: To the best of my knowledge  | e death occurred at the time, date and place                                       | and due to the ca                           | ause(s) and manner as stated.                           |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.                                     | Medical        | (Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.   | d/or investigation, in my opinion, death occu                                      | irred at the time, da                       | ate and place, and due to the cause(s)                  |
| To T<br>To 1  | Σ              | 29b. Signature and title of certifier  | 29c. License number  | 25  | 9d. Date signed (Month, Day, Year)                      |
|   |                | Mary D. Bivera-King  | 1 44747 47   |   | 01/7/7/0  |
| HV  |                | 30. Name and address of person who completed cause of death (Item 23a)  NANKY D. RIVERA-KING, MD. 120                                  | A MARDA LN., A   | ANNA POL                                    | 15, MD 21403  |
| Sta<br>Registr  | -              | 31. Date filed (Month, Day, Year)  APR 2 2 2010  32. Registrar's Signature   | Sark   |   |   |
|   |                | THE POID MANAGEMENT  | (1   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per daughter/POA G904 6/3/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Bernard Michael Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AMME BAUMORE WINE WASHINGTON MEDICAL ENTE 8. Date of Birth 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Days Months 64738/1930 Maryland 213 26 4906 Yrs Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Glen Burnie 1 Yes 2 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with Funeral 33 Cedar Drive 21060 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ 1 Yes If Yes, Give 1 🗆 Yes 2 🏝 No Maryland 21215-0036 Specify. White 3 🗌 Widowed 4 🗀 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 6th College (1-4 or 5+) Upholsterer Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence Smith Ada Beck 19a. Informant's Name/Relationship (Type, Print)

Margaret L. Smith

Alice Margaret Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21060 33 Cedar Drive Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 04/19/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final CofonAR-Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No is certificate has been signed by the a director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 3 🗆 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 Date signed (Month, Dav. Year) 29b. Signature and title of certifie 16 2010 ructeted cause of death (Item 23a) (Type, Print) e and address of person who co ABA Glev Burnip 20161 31. Date filed (Month, Day, Year 32. Receiver's Signature State 2 Registrar

Physic /Medi

|  | 1 - State Registrar   |                                      | Certificate of  |  |   | g. No. 201                        | 12536  |  |  |  |
|--|---|--------------------------------------|---|--|---|-----------------------------------|--|--|--|--|
| an                                     | 1. Decedent's Name (First, Middle, Last)  |                                      |   |  | Date of Death     Month                     | Day Year                          | 3. Time of Death                                 |  |  |  |
| cal                                    | GEORGE HENRY SCHAFFER JR  |                                      |   | Location of Death                          | April                                       | 20, 2010                          | 4:54 A <sup>M</sup>                              |  |  |  |
| ner                                    | 4a. Facility Name (If not institution, give street and number,  | 4c. County of Dea                    |   |  |   |                                   |  |  |  |  |
|  | Greater Baltimore Medica 5. Social Security Number 6. Sex 7. Ac   | ge (In yrs. last birth               | Towso   | N<br>If Under 24 Hrs.                      | 8. Date of Birth                            | Baltimo 9. Bir                    | thplace (State or Foreign                        |  |  |  |
|  | 213-01-8101 XXM 2 F 96  |                                      | rs. Months Days   | Hours Min.                                 | 8. Date of Birth<br>(Month, Day,<br>OCT 15, | 1913 Ma                           | ryland   |  |  |  |
|  | 10a. State 10b. County  | 10c. City, Town                      | or Location   |  |   |                                   | 10d. Inside City Limits                          |  |  |  |
| 햦                                      | Maryland Baltimore  | Tows                                 | on  |  |   |                                   | 1 □Yes 2√XNo                                     |  |  |  |
| ire                                    | 10e. Street and Number  | 10                                   | g. Citizen of What Co   | ountry?                                    |   |                                   |  |  |  |  |
| le<br>Le                               | 1055 West Joppa Road  |                                      | USA   |  |   |                                   |  |  |  |  |
| nue                                    | 11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □   | Ever in U.S.                         | <ol> <li>Was Decedent of H<br/>If Yes, specify Cuba</li> </ol>                  | ispanic Origin? (Sp<br>an, Mexican, Puerto | pecify Yes or No-<br>Rican, etc.)           | 14. Race - Am<br>Black, Whit      |  |  |  |  |
| Completed by Funeral Director          | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:   | No WWII                              | 1 □Yes 🌂 💢 No   | Specify:                                   |   | Specify:                          | White  |  |  |  |
| etec                                   | 15. Decedent's Education (Specify only highest grade completed)   |                                      | Decedent's Usual Occup<br>Give kind of work done of<br>life. DO NOT use retired | ation<br>during most of work               | ring  | 6b. Kind of Business              | /Industry  |  |  |  |
| dmo                                    | Elementary/Secondary (0-12) College (1-4or  | 5+)                                  | General Man   |  |   | Chemica                           | l  |  |  |  |
| Be C                                   | 17. Father's Name (First, Middle, Last)   |                                      |   |  | e (First, Middle, N                         |                                   |  |  |  |  |
| To B                                   | George Henry Schaffer Sr  |                                      |   | Mary Di                                    | insmore                                     |                                   |  |  |  |  |
| _                                      | 19a. Informant's Name/Relationship (Type. Print)  | 19b. I                               | Mailing Address (Street   | and Number or Rui                          | ral Route Number,                           | City or Town, State,              | Zip Code)  |  |  |  |
|  | George Henry Schaffer III   | Son 23                               | 5 Bahns Mil   | l Road Re                                  | ed Lion F                                   | Pennsylvani                       | ia 17356   |  |  |  |
|  | 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State  | 20b. Place of E<br>cemetery,         | Disposition (Name of crematory or other place                                   | ce)  | Date 2                                      | 20c. Location - City or           | Town, State                                      |  |  |  |
|  | 4 Donation 5 □ Other (Specify)  | GreenMo                              |   |  |   |                                   | re, Maryland                                     |  |  |  |
|  | 21. Schature of Funeral Segree Licensee 22. Name and Address of FMitchell-Wiedefeld Funeral 6500 York Road Baltimore, Maryland 21   |                                      |   |  |   |                                   |  |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                                      |   |  |   |                                   |  |  |  |  |
|  | Immediate Cours (Final  |                                      | ndrome  |  |   |                                   | Approximate Interval Between Onset and Death     |  |  |  |
| ı                                      | resulting in death)   | a consequence f                      |   |  |   |                                   | Tens   |  |  |  |
|  | Securation b Pheur  | nonia                                |   |  |   |                                   | Iweek  |  |  |  |
| iner                                   | Sequentially list conditions, if any, leading to himbolate cause. Enter Underlying Cause (Disease or injury that initiated events   | a consequence of                     | ye  |  |   |                                   |  |  |  |  |
| xam                                    | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as   | a consequence of                     | ٦.  |  |   |                                   |  |  |  |  |
| Completed by Physician/Medical Examine | bue to (or as   | a consequence of                     | <i>)-</i>   |  |   |                                   |  |  |  |  |
| gic                                    | d   |                                      |   |  |   |                                   |  |  |  |  |
| M/C                                    | IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant  | of pregnancy                         |   |  |   | 23d. Date of de                   | elivery  |  |  |  |
| iciai                                  | in the past 12 months?  | 2 ☐ Fetal death<br>at time of death  | 3 ☐ Ectopic pregnanc<br>5 ☐ Other (specify) _                                   | У  |   | Month                             | Day Year   |  |  |  |
| hys                                    | 9 Unknown   |                                      |   |  |   |                                   |  |  |  |  |
| y P                                    | Part II. Other significant conditions contributing to death I   | out not resulting in t               | the underlying cause giv  | en in Part I.                              | 23e. Did tob                                | acco use contribute t             | to the cause of death?                           |  |  |  |
| edk                                    | _ Aortic aneurysms  |                                      |   |  | 1 □ Ye                                      | s 2 √No 3 ∏ F                     | robably 4 🗆 Unknown                              |  |  |  |
| plet                                   | J   |                                      |   |  | 24a. Was ar                                 |                                   | utopsy findings available completion of cause of |  |  |  |
| ĕ                                      |   |                                      |   |  | perforn                                     | ned?   death?                     | s 2 No   |  |  |  |
| Be (                                   | 25. Was case referred to medical examiner?  |                                      |   |  | th (Check only one                          |                                   |  |  |  |  |
| 2                                      | 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpat  |                                      | oatient 3 DOA Oth   | 4 Li Nursing H                             | ome 5 Reside                                | nce 6 Other (Sp.                  | ecify)   |  |  |  |
| on:                                    | 27. Manner of Death 28a. Date of Inj<br>1 ☑ Natural 5 ☐ Pending (Month, Da  | ury 28b. Tir<br><i>ay, Year)</i> Inj | ury Wor   |  | 28d. Describe ho                            | w injury occurred                 |  |  |  |  |
| Cat                                    | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 200 Blace of the  | At harry favor                       |   | Yes 2 □ No                                 | 006 1                                       |                                   | 2 and Davids Marie and                           |  |  |  |
| ertif                                  | determined   200. Place of III  | tc. (Specify)                        | n, street, factory, office  |  | City or Town                                | reet and Number or F<br>ı, State) | turai Houte Number,                              |  |  |  |
| Ŭ<br>m                                 | 29a. Certifier 1 ☑ Certifying Physician: To the best  | of my knowledge.                     | death occurred at the ti  | me, date and place                         | , and due to the c                          | ause(s) and manner                | as stated.                                       |  |  |  |
| Medical Certification: To              | (Check only one) 2 Medical Examiner: On the basis and manner s  | of examination and                   |   |  |   |                                   |  |  |  |  |
| ğ                                      | 29b. Signature and title of certifier   | MA                                   | 29c. Licens   |  |   | 9d. Date signed (Mon              |  |  |  |  |
|  | Renn E. Thomas  | MD                                   | D60   |  |   | 4/20/201                          | <i>O</i>   |  |  |  |
|  | 30. Name and address of person who completed cause of Renu Thomas, MD 67  | death (Item 23a) (T                  | ype, Print)<br>harles St.   | Towson                                     | , MD 2                                      | 21204                             |  |  |  |  |
| ite<br>ar                              | 31. Date filed (Month, Day, Year) 32. Reg   | rar's Signature                      | harles St.  |  |   |                                   |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M 7:33PM 2000 TILBEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 3601 ANTON FARMS ROAD BALTIMORE Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 5/15/1913 Months Davs Hours 96 450-48-2316 NY Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 21208 3601 ANTON FARMS ROAD USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. o. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: WHITE "natural" 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 12 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SAMUEL LOWITZ KATIE SCHMUCKLER permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MORRIS SILBERMAN/HUSBAND 3601 ANTON FARMS ROAD, BALTIMORE, MD 21208 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, BETH EL MEMORIAL PK 4/21/2010 | RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on yach ling. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Bequir tielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year ☐ Pregnant at time of death☐ Unknown page 2 should be detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 Yes 2 🗆 No Yes or Attending Physician: 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Exertifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

KATULSSN C.

31. Date filed (Month, Day, Year)

AFK ZZ ZIII

-2835

32. Registrar's Signature

Smire Aus #303

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Todd Aphelia Ray Melissa 2010 6:11a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Randallstown</u> Season's Hospice 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X□ F Months Hours (Month, Day, Year) Country) Director 239-24**-**3482 28a-f shov 10c. City, Town or Location 10a, State aţ 10b. County 10d. Inside City Limits Director notified 1 X Yes 2 No NA Baltimore MD 10f. Zip Code 5 10e. Street and Numbe 10g. Citizen of What Country? ms 23a or must be n Funeral Cordelia filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. 5 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black "natural" 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Home Housewife 12th grade na traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Page 1 and 2 should be Mary K. Davis Friendly D. Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ave, Baltimore, Md 21215 Cordelia Todd-Husband hod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 4/26/2010 Crownsville, rowrsville Vet Funeral Service Licensee 22. Name and Address of Eacility March F/H West 4300 Wabash Av Signatu Ave, Baltimore, 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Imm, diate Cause (Final ase or condition resulting in death) 43 Culo Physician Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initiary that initiated events.) Examine Due to (or as a consequence of). burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Hospital or Attending Physician: The law requires that the death Day Pregnant at time of death 5 Other (specify) Unknown the page 2 should be detached 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Mille M DA768 18/10 Va 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith 2835 Ave Barrer 21209 Mille Somle M Kaymony 702 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charles E. Vanneman 2010 7:09 P. M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford County Examiner 1001 Southern Drive Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Min. 214-14-9851 1**X** M 2 □ F Hours March 28, 1921 89 Director Maryland Usual Residence of Decedent of Montal Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Directo Bel Air Harford County Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1001 Southern Drive 21014 United States filed within 72 hours after death with Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) State Farm Insurance C.L.U. 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Mildred Myers Charles E. Vanneman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Coteswood Circle, Cockeysville, Maryland 21030 Lynn Van Natta (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 4/23 2010 Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
3 Newbort Drive, Forest Hill, Maryland 21 21. Signature of Funeral Service Licensee Jes-Lean of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death tollule Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 2 🗌 No 1 Yes 25. Was case referred to a 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Mann Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 🗌 Pending Natural 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

PR 22

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |   | For State  | State o   | f Marylar  | nd / Depa<br><i>Cer</i> | artment of F<br>tificate of L    | Health and I<br>Death |                         | Lan V               | 0 1 0                        | 12540   |  |
|---------------------|---|---|--|---|--|-------------------------|----------------------------------|-----------------------|-------------------------|---------------------|------------------------------|---|--|
|                     | •   |   | Registrar  1. Decedent's Name (First, Middle,  | Last)   |  |                         | imouto or E                      |                       | 2. Date of Dea          | Reg. No.<br>ath     |                              | 3. Time of Death                                |  |
|                     | Physicia<br>Medic   |   | Robert Voelkel   |   |  |                         |                                  |                       | April                   | 13 <sup>bay</sup>   | 20 10                        | 7:24 P M  |  |
|                     | Examin  | er  | 4a. Facility Name (if not institution, Gilchrist Hosp:   |   | (ber)  |                         | 4b. City, Town, or<br>Towsor     | Location of Death     | 1                       |                     | ty of Deat                   |   |  |
|                     | Funeral   |   |  | 6. Sex  | 7. Age (In yrs.                                    | last birthday)          | If Under 1 Year                  | If Under 24 Hrs.      | 8. Date of Birt         | h                   | 9. Birt                      | hplace (State or Foreign                        |  |
|                     | Director  |   | 216-28-4085  | 1 🖾 M 2 🗆 F   | 78   | Yrs.                    | Months Days                      | Hours Min.            | Aug 19                  | <sup>Year</sup> 931 | Mary                         | y Land  |  |
|                     | and<br>show<br>lat  | or  | Usual Residence of Decedent  10a, State 10b, County  |   | 10c. Ci  | ty, Town or Loc         | ation                            |                       |                         |                     |                              | 10d. Inside City Limits                         |  |
|                     | Maryla<br>28a-f<br>otified  | irect   | MD   |   | Ва   | altimor<br>——           | e                                |                       |                         |                     |                              | ¹X☐ Yes 2 ☐ No                                  |  |
|                     | th the<br>3a or<br>t be n   | Funeral Director  | 10e. Street and Number   |   |  |                         | 10f. Zip Code                    |                       |                         | 10g. Citizen o      | f What Co                    | untry?  |  |
|                     | ems 2   | nue   | 912 W. Lake Ave  |   | dent Ever in U.                                    | S. 13. V                | 21210 Vas Decedent of H          | ispanic Origin? (Sp   | pecify Yes or No-       | USA_                | ace - Amer                   | American Indian,                                |  |
| 9200-61212          | rs after de<br>iral", or it<br>Examine  | Completed by F  | 1 ☐ Never Married 2 🛣 Marri<br>3 ☐ Widowed 4 ☐ Divorced  |   | rces?<br>2   No 19!                                | 52- "                   | Yes, specify Cuba  ☐ Yes 2 🔀 No  | ın, Mexican, Puerto   | o Rican, etc.)          | BI                  | ack, White<br>fy: <b>whi</b> | e, etc.   |  |
| 2                   | 72 hou<br>"natu<br>edical   | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |   |  |                         |                                  |                       |                         |                     |                              | Industry  |  |
| 7.17                | vithin 7<br>iene.<br>rr than<br>the M   | Elementary/Seconday (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) redeveloper  17. Father's Name (First, Middle, Last)  |  |   |  |                         |                                  |                       |                         |                     |                              |   |  |
| ם                   | filed v<br>al Hyg<br>d othe   | Be C  | king industry<br><sup>TO)</sup>  |   |  |                         |                                  |                       |                         |                     |                              |   |  |
| Z                   | uld be<br>I Ment<br>narke<br>natic  | 잍   | Robert Emmett V  |   |  |                         |                                  |                       |                         |                     |                              |   |  |
| , Ma                | nd 2 sho<br>lealth and<br>m 27 is r   |   | 19a. Informant's Name/Relationsh Alice Voelkel/s   | State, Zip<br>Land  | 21210  |                         |                                  |                       |                         |                     |                              |   |  |
| Baitimore, Maryland | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                   |   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S)   | n - City or Town, State   |  |                         |                                  |                       |                         |                     |                              |   |  |
| pall                | permit<br>Depart<br>Impor<br>any in   |   | 21. Signative peral Service Li<br>kona I d. S  | imore   | Street   |                         |                                  |                       |                         |                     |                              |   |  |
|                     | nysician/   |   | 23a. Part 1. Enter the disease, or<br>shoot, or heart failure. List of<br>Immediate Cause (Final<br>disease or condition |   | Approximate<br>Interval Between<br>Onset and Death |                         |                                  |                       |                         |                     |                              |   |  |
|                     | Medical Examiner  |   | resulting in death)  Du to (or as a consequence of):   |   |  |                         |                                  |                       |                         |                     |                              |   |  |
|                     | ited<br>d<br>insit  | aminer  | Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury              | Due to (  | or as a conseq                                     | uence of):              |                                  |                       |                         |                     |                              |   |  |
| 2                   | ate be executed<br>physician and<br>the burial-transi   | edical Examin   | that initiated events<br>resulting in death) Last  | Due to (d   | or as a conseq                                     | uence of):              |                                  |                       |                         |                     |                              |   |  |
|                     | ficate<br>ig phy  |   | IE EENANI E.   | 0   |  |                         |                                  |                       |                         |                     |                              |   |  |
| POX PO              | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                  |   | Birth 2 ☐ Fet<br>nant at time of                   | al death 3              | Ectopic pregnand Other (specify) | ey .                  |                         |                     | ate of deli<br>Ionth         | ivery<br>Day Year                               |  |
| IS, P.O.            | uires that th<br>in signed by<br>uld be detac   | by  | Part II. Other significant condition   | ns contributing to de   | eath but not re                                    | sulting in the u        | nderlying cause giv              | ven in Part I.        |                         |                     |                              | the cause of death?                             |  |
| Vital Records,      | The law rec<br>ate has bee<br>bage 2 sho  | Completed   |  |   |  |                         |                                  |                       | 24a. Was a autop perfor | sv                  | prior to death?              | topsy findings available completion of cause of |  |
| <u> </u>            | cian:<br>sertifica<br>ector, I  | Be  | 25. Was case referred to medical examiner?   | Hospital:   |  |                         |                                  | ace of Death (Chec    | ck only one)            |                     |                              |   |  |
| OT V                | r this caral dir  | e: To   | 1 ☐ Yes 2 🔀 No<br>27. Manner of Death  | 28a. Date o   | Inpatient 2  of injury                             | 28b. Time of            | t 3 DOA Othe                     | 4 ☐ Nursing H         | ome 5 Resid             |                     |                              | ity) WS LLP                                     |  |
|                     | ath.<br>r: Afte   | icat  | 1 Natural 5 Pending Pending Investig   | ation   | h, Day, Year)                                      | injury                  | work                             | ?<br>Yes 2□No         |                         |                     |                              |   |  |
| DIVISION            | ral or Atters after de al Directo   | 27. Manner of Death  1 Natural 2  |  |   |  |                         |                                  |                       |                         |                     |                              |   |  |
|                     | he Hospii<br>in 24 hou<br>he Funera<br>ipleted fill   | Medical   | (Check 2 L Medical Ex  | Physician: To the be<br>caminer: On the basi<br>Nurse Practioner: T | is of examinatio                                   | n and/or invest         | igation, in my opinic            | on, death occurred a  | at the time, date ar    | nd place, and d     | lue to the c                 | cause(s) and manner stated.                     |  |
|                     | To t<br>To 1  |   | 29b. Signature and title of certifier  | ho  |  |                         | 29c. License                     | s number              | 5                       | 29d. Date sign      | ed (Month                    | 7. Day, Year)                                   |  |
|                     |   |   | 30. Name and address of person w   | ho completed cause  |  | n 23a) (Type, P         | rint) A                          | ronces                | ST ROW                  | m.                  | ng                           |   |  |
|                     | Stat<br>Registra  |   | 31. Date filed (Month, Day, Year)  | 32. Re  | egistar's Signa                                    | ature                   | backet                           |                       |                         |                     |                              |   |  |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:04 А. м Eugene Preston Widenhouse Apri] 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country Kannapolis, North Carolina **Funeral** (Month, Day 1**XX**M 2 □ F Months Days Hours 81 17,1928 **Director** 240-36-2120 November Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code Citizen of What Country? United States Funeral 21224 7829 E. Baltimore Street of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Eastern Elementary/Seconday (0-12) Stainless Steel office worker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomas Martin Widenhouse Lottie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7829 E. Baltimore Street Kenneth L.C. Widenhouse/ son Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral
Chapel Bel Air 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Forest Hill, Maryland 21. Signature Fundal Service License 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition Onset and Death 10 beti Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the a Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has but director, page 2 sl autopsy perform 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 1 Inpatient 2 I this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

The Funeral Director: After the pleted filled in by the funeral Certificate: Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accid 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Tpleted i (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nand title of certifie 29b. Signature 29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Menth, Day, State Registrar

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| 1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 10 1254   |                           |  |   |   |                         |                          |                         |                   |               |                                |           |                       | 51,                 |                              |              |
|---|---------------------------|--|---|---|-------------------------|--------------------------|-------------------------|-------------------|---------------|--------------------------------|-----------|-----------------------|---------------------|------------------------------|--------------|
|   |                           | Registrar  1. Decedent's Name (First, Middle, I                                | Last)   |   | Ce/                     | uncate                   | ם וט כ                  | eauri             |               | 2. Date of D                   | eath      |                       | IU                  | 3. Time of                   | Dooth .      |
| Physicia  |                           | Frances  | D.  | Mai   | sberg                   |                          |                         |                   |               | Month<br>April                 | 20 D      | 2010 <sup>Y</sup>     | ear/                | 8:00                         |              |
| Medic<br>Examin   |                           | 4a. Facility Name (if not institution, g                                       |   |   | SUCIE                   | 4b. City,                | Town, or                | Location          | of Death      | приц                           | 4         | c. County of          | Death               | 10.00                        | Α            |
| 1   |                           | 1706 Lauterb   | ach Road  |   |                         | F                        | inks                    | burg              |               |                                |           | Carr                  | :011                |                              |              |
| Funeral   |                           |  |   | Age (In yrs. la                                 |                         | If Under<br>Months       |                         | If Under<br>Hours | 24 Hrs.       | 8. Date of Bi                  |           | - 9                   | Birtho              | lace (State o                | r Foreign    |
| Director  |                           | 216-09-0616  | T L I M Z ZA F                                      | 92  | Yrs.                    |                          | ,-                      |                   |               | Feb 27                         | ,191      | 18 1                  | Mary                | land                         |              |
| land<br>show<br>dat   | 'n                        | Usual Residence of Decedent  10a. State 10b. County                            |   | 10c. Cit  | y, Town or Loc          | ation                    |                         |                   |               |                                |           |                       | 1                   | 0d. Inside Cit               | ty Limits    |
| faryla<br>Ba-f s  | ect.                      | Maryland Carro   | 11  |   | Finks                   | huro                     |                         |                   |               |                                |           |                       |                     | 1 🗌 Yes                      | 2 🕅 No       |
| the N<br>r or 2   | ΙĎ                        | 10e. Street and Number   |   |   | 1 21110                 | 10f. Zip                 | Code                    |                   |               |                                | 10g. C    | Citizen of Wh         | at Coun             | try?                         |              |
| s 23s   | Funeral Director          | 1706 Lauterbach  | Road  |   |                         | 2                        | 1048                    | }                 |               |                                |           | USA                   |                     |                              |              |
| death<br>'item<br>ner n   |                           | 11. Marital Status   | 12. Was Deceder<br>Armed Force                      | s?  | 3. 13. V                | Vas Decede<br>Yes, speci | ent of His<br>Ify Cuban | panic Ori         | gin? (Spe     | cify Yes or No<br>Rican, etc.) |           | 14. Race -            | America<br>White, e |                              |              |
| after after all", or xami   | d by                      | 1 ☐ Never Married 2 ☐ Marrie<br>3 🌠 Widowed 4 ☐ Divorced                       | If Yes, Give  |   |                         | ☐ Yes 2                  |                         |                   |               |                                |           | Specify:              |                     |                              |              |
| 5-UU36<br>2 hours after<br>"natural", o<br>edical Exam  | lete                      | 15. Decedent'  |   | s.  | 16a. Deced              | ent's Usual              | I Occupa                | tion              |               | -                              | 16b       | Kind of Busin         | Whi                 |                              |              |
| ING Z1Z13-UU30  • filed within 72 hours after death with the Maryland the lygiene.  d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at   | Completed by              | (Specify only highest<br>Elementary/Seconday (0-12)                            | grade completed) College (1-4 d                     | or 5+)  | (Give I                 | and of work<br>NOT use   | k done du               |                   | t of workii   | ng                             | 100.      | Tallia of Basil       | 1033 1110           | dony                         |              |
| Id Z1   |                           | 12   | n/a   |   | Busi                    | ness                     | Woma                    | n-Se              | 1f Er         | nployed                        | 1         | Retai                 | .1                  |                              |              |
| be filed yeental Hygic event,   | To Be                     | 17. Father's Name (First, Middle, Las  | st)   |   |                         |                          |                         | 18. Mothe         | er's Name     | (First, Middle                 | , Maider  | n Surname)            |                     |                              |              |
| raryian<br>should be fill<br>and Mental<br>is marked c  |                           | Peter  | Jasko   |   | 1                       |                          |                         |                   | artha         |                                |           | <u>leszcz</u>         | ,                   |                              |              |
| Mal   |                           | 19a. Informant's Name/Relationship   |   |   |                         | -                        |                         |                   |               | Route Numb                     |           |                       |                     |                              |              |
| e al pud  |                           | Barbara A. Burk 20a. Method of Disposition                                     | e/Daugntei  |   | 1 138<br>lace of Dispos |                          |                         | <u>Koad</u>       |               | arks, N<br>Date                |           | Land<br>Location - Ci | 211.                |                              |              |
| DalltIMOre permit. Page 1 a Department of H Important: If ite any injury or ott   |                           | 1 ☑ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe                      |   | ate c   | emetery, crem           | natory`or ot             | her place               | ' i '             | 4/26/         | /10                            |           |                       | •                   |                              |              |
| Dallimo<br>permit. Page '<br>Department o<br>Important: If<br>any injury or once.   |                           | 21 Supply of Funeral Service An  |   | שען   | aney V                  | Name and                 | Address                 | of Facilit        | tv            |                                |           | Timoni                | - 1                 |                              |              |
| Bange a   |                           | Bryanck  | LL CO   |   |                         | Lemmo:                   | n Fu<br>Pad             | nera.<br>onia     | 1 Hon<br>Road | ne of I                        | ula:      | ney Va<br>m. Mar      | lle                 | Inc.                         | 093          |
|   |                           | 23a. Part 1. Enter the disease, or co<br>shock or heart failure. List onl      | omplications that cause on each                     | sed the deati                                   |                         |                          |                         |                   |               |                                |           |                       | 1                   | Approximate<br>Interval Betv | е            |
| Physician   | 8 8                       | Immediate Cause (Final disease or condition                                    |   |   | al in                   | faret                    | im                      | ~                 |               |                                |           |                       |                     | Onset and D                  |              |
| Medical Examiner  |                           | resulting in death)  |   |   | ence of):               |                          |                         |                   |               |                                |           |                       | $\neg$              |                              |              |
|   | -                         | Sequentially list conditions,  | ν. –  | as a consequ                                    |                         | . can                    | au a                    | vasa              | ula           | r dise                         | eas       | e                     | _                   |                              |              |
| ed  | ᇤ                         | if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury | Due to (or a  | as a consequ                                    | ience or);              |                          |                         |                   |               |                                |           |                       |                     |                              |              |
| xecut<br>n and<br>al-trar   | Exa                       | that initiated events<br>resulting in death) Last                              | C. Due to (or a                                     | as a consequ                                    | ence of):               |                          |                         |                   |               |                                |           |                       | +                   |                              |              |
| ate be executed physician and the burial-transit  | dical Examiner            |  | d   |   |                         |                          |                         |                   |               |                                |           |                       |                     |                              |              |
| ifficate<br>ng ph   |                           | IF FEMALE:   |   |   |                         |                          |                         |                   |               |                                |           |                       |                     |                              |              |
| requires that the death certificate is been signed by the attending physishould be detached for use as the  | Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?                              | 23c. If yes, outcom                                 | ne of pregna<br>h 2 🗌 Feta                      | death 3                 |                          |                         | ,                 |               |                                |           | 23d. Date of          |                     | -                            |              |
| box<br>e death<br>the atter   | ysic                      | 1 Yes 2 X No<br>9 Unknown  | 4 ☐ Pregnan<br>9 ☐ Unknow                           |   | leath 5 ∟               | Other (spe               | ecify)                  |                   |               |                                |           | Month                 |                     | Day Y                        | <b>'e</b> ar |
| od by   | F.                        | Part II. Other significant conditions  | s contributing to deatl                             | n but not res                                   | ulting in the u         | nderlying ca             | ause give               | n in Part I       | Į.            | 23e. Did 1                     | tobacco   | use contribu          | rte to the          | e cause of de                | eath?        |
| signe<br>d be o   | d b                       | Atrial fibrill   | ation   |   |                         |                          |                         |                   |               |                                |           | 2 <b>∑</b> No 3       |                     |                              |              |
| aw requires<br>as been sig  | lete                      | Rheuma fic   |   | <00c  | e                       |                          |                         |                   |               | 24a. Was                       | an        | 24b. Wer              | re autop            | sy findings a                | vailable     |
| he law<br>te has<br>age 2 a   | E O                       | Stroke   | - 200 11 000  | J   | · · · · ·               |                          |                         |                   |               | auto                           | ormed?    | dea                   | th?                 | npletion of ca               | use of       |
| an: Tl<br>an: Tl<br>tifical<br>tor, pa  | e<br>C                    | 25. Was case referred to medical   |   |   |                         |                          | 26. Plac                | ce of Deat        | th (Check     | 1 🗆 Yes<br>only one)           | 2 10 1    | \o_ 1 ∟               | J Yes               | 2 📈 No                       |              |
| ysici<br>ysici<br>iis cer<br>direc  | To B                      | examiner?<br>1 ☐ Yes 2 💢 No  | Hospital:   | atient 2 🗆                                      | ER/Outpatien            | t 3 □ DO                 | A Other                 | : 4 □ Nu          | ursing Hor    | ne 5 Resi                      | dence     | 6 🗍 Other (S          | Specify)            |                              |              |
| ng Pl   | ite:                      | 27. Manner of Death 1   Natural 5 □ Pending                                    | 28a. Date of in<br>(Month, I                        | njury<br>Day, Year)                             | 28b. Time of injury     | 28                       | c. Injury a             |                   | 2             | 8d. Describe                   | how inju  | ry occurred           |                     |                              |              |
| tendi<br>leath.<br>tor: A<br>the fu   | įįį                       | 2 Accident Investiga 3 Suicide 6 Could no                                      | t be  |   |                         | М                        |                         | es 2 🗆            | No            |                                |           |                       |                     |                              |              |
| or At<br>or At<br>after of<br>Direct<br>in by   | Certificate:              | 4 Homicide determine   | 28e. Place of I                                     | njury - At ho<br>etc. <i>(</i> S <i>pecify,</i> | me, farm, stre          | et, factory,             | office                  |                   | 2             | 28f. Location (<br>City or To  |           |                       | r Rural I           | Route Numbe                  | er,          |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical                   | 29a. Certifier 1 Certifying P  | hysician: To the best                               | of my knowl                                     | edge death o            | ccured at the            | he time                 | date and r        | place and     | due to the ca                  | ause(s) a | and manner a          | ıs staten           |                              |              |
| n 24 h  | Medi                      | (Check 2 ☐ Medical Exa   | aminer: On the basis of<br>lurse Practioner: To the | f examination                                   | ı and/or investi        | gation, in m             | ny opinion              | , death oc        | curred at     | the time, date:                | and place | e, and due to         | the cau             | se(s) and mar                | iner stated  |
| Vithii comp   | ٦                         | 29b. Signature and title of certifier  |   |   |                         | 29c.                     | License r               | number            |               |                                |           | ate signed (N         |                     |                              |              |
|   |                           | Tuls   | 22 W  | 5   |                         | į                        | 240                     | 12                | 77            |                                |           | Apri1                 | 21,                 | 2010                         |              |
|   |                           | 30. Name and address of person wh  |   |   |                         |                          |                         |                   |               |                                |           |                       |                     |                              |              |
|   |                           | Thomas S. Wilso 31. Date filed (Month, Day, Year)                              |   |   |                         | en B                     | lvd.                    | , sui             | ite 5         | 00, Ba                         | 1tin      | nore,                 | MD                  | 21239                        |              |
| Stat<br>Registra  |                           | APR 222  | 2010 32. regis                                      | strar's Signat                                  | 1. <b>1</b>             | 200                      |                         |                   |               |                                |           |                       |                     |                              |              |
| 0HMH 17 Rev 7/20  |                           |  | -VI   | -   | 1                       |                          |                         |                   |               |                                |           |                       |                     | •                            |              |

DHMH 17 Rev 7/2009

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AMEND ITEM# 1perPHYS, G904, 6/9/2010, WS

For Amend Item 26 per verb., g902, 04/22/2010 dnb

For State of Maryland Department of Health and Mental Hygiene
Registrar

Certificate of Dooth 12544 1. Decedent's Name (First, Middle, Last)

Marguerite E. Woodhull

Margurite E. Woodhu 2. Date of Death 3. Time of Death **Physician** Day Year Woodhull April 3,2010 1:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Airy
Vaar | HUnder 24 Hrs. 713 Midway Apt.302 Μt Carroll Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Director 143-10-4956 96 June23,1913 England Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 🔀 No Maryland Carroll Mt. Airy 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Midway, Funeral Apt.302 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No <u>\$</u> Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic ev 2 James M. de la Haye Ada Michel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Woodhull/Son 226 St. Mark Way, Westminster, Maryland21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4-17-10 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muchaci 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cachesia and burial-trai the attending physician the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I ☐Yes 2 ■ No 9 Unknown ģ significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. <u>^</u> director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed' 2 No 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Certification: To 1 ☐ Yes 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence this o Other (Specify, 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 📤 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 2 29b. Signature erson who completed cause of deam (Item 23a) (Tvr 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April1 Physician/ 20°10 2:10 Рм James Walls Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Blue Point Nursing Home If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 Unk **Funeral** 1 ☑ M 2 ☐ F Months Davs Hours Min. NoWonth8Day, 1926 221-14-6852 83 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Baltimore 1<sup>X</sup>☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 W. Belvedere Avenue 21215 USA 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces?Unk
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after Specify: White 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry unk (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last)  $u\overline{n}\overline{k}$ 18. Mother's Name (First, Middle, Maiden Surname) unk ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Kleacon/guardian Calvert St; Baltimore, Maryland 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Cher (Specify) in State cemetery, crematory or other place. State Anatomy Board; 655 W. Baltimore Street 21. Signature of Funeral Sa S Licensee Enter the disease, or complications that caused the death, heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Parysician/ disease or condition Medical resulting in death) Examiner countially list our Ultions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ó 4 ☐ Pregnant at time of death 9 ☐ Unknown Other (specify) signed by the and do be detached for To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Tes 2 10 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) and title 29b. Signature

Registrar

State

SUTH

2835

32. Regiş

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALKITT MO

31. Date filed (Month, Day,

01

SAZTIMONE, MI)

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2546 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Howard Wilkins, Jr. 4:50 А. м April 20 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Future Care of the Chesapeake Arnold 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 02/26/1926 9. Birthplace (State or Foreign 1**₹** M 2□ F Months Days Hours Min 84 North Carolina 214 24 1058 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4213 Grace Court 21226 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: If Yes, Give WW II Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Repairman Appliance Shop 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Wilkins Sr. (not available) Rlanche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tomesena Mitchum / Caretaker 95 Metispa Drive Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 04/23/2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or shock, or heart failure. List blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final UNG 3 MONTHS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery Month Year Day

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

ò

23a

"natural", or items

is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany or other traumatic event

Director

Funeral

þ

Completed

Be

ပ

traumatic event, the Medical Examiner must be notified at

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

Examine Physician/Medical

physician and s the burial-trans attending p for use as 1 s been signed by the should be detached certificate has been page 2 s director, After this filled in by the funeral

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Completed by Medical Certification: To Be

|   | d   |   |
|---|---|---|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy  1  | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions   | contributing to death but not resulting in the underlying cause given in Part I.                  | se. Did tobacco use contribute to the cause of death?   |
| Domen   | T/A   | 1 Yes 2 No 3 Probably 4 Unknown   |
|   |   | la. Was an autopsy performed death?  □ Yes 2 □ No   1 □ Yes 2 □ No   No   No   No   No   No   No   No |
| 25. Was case referred to medical examiner?  | 26. Place of Death (Chec  | k only one)   |
| 1 Yes 2 DH6   | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5                     | ☐ Residence 6 ☐ Other (Specify)   |
| 27. Manner of Death 1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investigation                  | 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  28c. Injury at Work?  1 □ Yes 2 □ No | escribe how injury occurred   |
| 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined                                     | 286. Place of injury - At nome, farm, street, factory, office   28f. Loc                          | cation (Street and Number or Rural Route Number,<br>y or Town, State)                                 |
| 29a. Certifier 1 ☐-Certifying Ph  | ysician: To the best of my knowledge, death occurred at the time, date and place, and due         | e to the cause(s) and manner as stated.   |

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No ĺΝο e 6 Other (Specify) njury occurred

3 Probably 4 ☐ Unknown

| 2 Accident                            | investigation                              |   | M                            | 1 ☐ Yes 2 ☐ No  |   |  |  |  |  |
|---------------------------------------|--|---|------------------------------|---|---|--|--|--|--|
| 3 🗍 Suicide<br>4 🗍 Homicide           | 6 Could not be determined                  | 28e. Place of Injury - At home, farm, s building, etc. (Specify)  | street, facto                | ry, office  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |
| 29a. Certifier<br>(Check only<br>one) | 1 ☐ Certifying Physi<br>2 ☐ Medical Examin | ician: To the best of my knowledge, dea<br>er: On the basis of examination and/or<br>and manner stated. | ath occurre<br>investigation | dat the time, date and pla<br>on, in my opinion, death oc | ce, and due to t<br>curred at the tim   | he cause(s) and manner as stated.<br>he, date and place, and due to the cause(s) |  |  |  |
| 29b. Signature and                    | title of certifier                         | A. July,  | , 1                          | Oc. License number  | 3(00)   | 29d. Date signed (Month, Day, Year)  APPL 70, 7010                               |  |  |  |

within 24 hours after death.

To the Funeral Director: A the Hospital

completely

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

| 10-02905            |  |
|---------------------|--|
| Helene Marie Bailey |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

|  | • | 2 | 0 | - | 0 | - Constitution | 2 | 5 | L | - |
|--|---|---|---|---|---|----------------|---|---|---|---|
|--|---|---|---|---|---|----------------|---|---|---|---|

| * *   |  | 1- For State Certificate of Death Reg. No.   |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
|---|--|--|---------------------------------------|----------------------|-------------------|-------------------------|---|-------------|-------------------------|-------------------------|---|--|--|
| Physici   | an/  | 1. Decedent's Name (First, Mide  | lle,Last)                             |                      |                   |                         |   | 2.          | Date of Death<br>Month  | n<br>Day Yea            | 3. Time of Death  |  |  |
| Medical Exam  | iner   | Helene M.  | Bailey                                |                      |                   |                         |   |             | April 13, 20            | 010                     | 1136 nrs  |  |  |
|   |  | 4a. Facility Name (if not instituti  | on, give street and num               | ber)                 | 4                 | b. City, Town, o        | or Location of  | of Death    |                         | 4c. County c            |   |  |  |
|   |  | 116 Liberty Way  |                                       |                      |                   | Fruitland               |   |             |                         | Wicomic                 |   |  |  |
| Funeral   |  | 5. Social Security Number  | 1                                     | . Age (In yrs. la    | ast birthday)     | If Under 1 Ye Months Da |   |             | 8. Date of Birth        | 1(MM/DD/YYYY            | Birthplace (State or Foreign                                      |  |  |
| Director  |  | 062-50-3864  | 1 M 2 KF                              | 54                   | Yrs.              | WIOTUIS                 | ys Hours  | `   'V''''  | 09   15                 | 1955                    | NewyYork  |  |  |
| ,   |  | Usual Residence of Decedent  |                                       |                      |                   |                         |   |             |                         |                         | Land leader Oit Liebs   |  |  |
| w any   |  | 10a. State 10b. County   |                                       |                      | Town or Location  |                         |   |             | 10d. Inside City Limits |                         |   |  |  |
| Aaryland<br>28a-f show<br>1 at once.  | ō  | Maryland Wid   | omico                                 | Fr                   | ruitland          |                         |   |             |                         |                         | 1 X Yes 2 No  |  |  |
| Maryl<br>28a-   | Director   | 10e. Street and Number   | 7                                     |                      |                   | 10f. Zip Code           | 26  |             | 10                      | g. Citizen of Wh<br>USA | -   |  |  |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.  |  | 117 Liberty V  | ay                                    |                      |                   | 2182                    | 20  |             |                         | USA                     |   |  |  |
| n with  | Funeral  | 11. Marital Status   | Assess For                            | dent Ever in U.      |                   | Decedent of H           |   |             |                         | 14. Race<br>White       | - American Indian, Black,<br>e etc.                               |  |  |
| deatl<br>or ite<br>must   | Ë  |  | 1 Yes                                 | 2 X No               |                   |                         |   |             | ouri, oto.,             |                         |   |  |  |
| after   | þ  |  | vorced If Yes, Give Year<br>or Dates: |                      |                   | Yes 2X N                |   |             |                         |                         | white   |  |  |
| hours<br>natu   | 15. Decedent's Education (Specify only highest grade completed)    16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired)   16. Kind of Busines during most of working life. DO NOT use retired   16. Kind of Busines during most of working life. DO NOT use retired   16. K |  |                                       |                      |                   |                         |   |             |                         |                         | siness/industry   |  |  |
| 36<br>in 72<br>han "  | plet   | Elementary/Secondary (0-12)  | College (1-4                          | or 5+)               | gale              | s cler                  | e   |             |                         | retail                  | store   |  |  |
| 15-003<br>illed withi<br>Hygiene,<br>d other th   | E O  | 17. Father's Name (First, Middle   | l aet)                                |                      | Sare              |                         |   | 's Name (F  | irst Middle M           | aiden Surname)          |   |  |  |
| 1215-0036<br>Id be filed within 72 hours aft,<br>fental Hygiene.<br>narked other than "natural"<br>event, the Medical Examine.  |  | Thomas G. Gor  |                                       |                      |                   |                         |   |             | . Bouch                 |                         |   |  |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than  | To Be  | 19a. Informant's Name/Relation   | n, State, Zip Code)                   |                      |                   |                         |   |             |                         |                         |   |  |  |
| e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once   |  | 19a. Informant's Name/Relationship (Type, Print)       19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St         Maria Pippen/sister       1101 Calebs Way, Salisbury, MD 2180   |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
|   |  | 20a. Method of Disposition   | City or Town, State                   |                      |                   |                         |   |             |                         |                         |   |  |  |
|   | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Salisbury Crematory 4 1   |  |                                       |                      |                   |                         |   |             |                         | Salis                   | sbury, MD   |  |  |
| Baltimo<br>permit. Pag<br>Department<br>Important:  |  | 4 Donation 5 Other S<br>21. Sign ture Funeral Say co   | pecify:                               |                      |                   | 1711                    |   | 13          | ,                       |                         |   |  |  |
| Baltimo<br>permit. Page<br>Department<br>Important:   |  | 21. Sgridure of Funeral Styles Usersale 22 Name-and Address of Facility Funeral Home Professional Assertation Funeral Funeral Home Professional Assertation Funeral Fu |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| Physician   | -  | 23a Part I. Enter the disease, or complications that sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart   |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| the dical.  | A  | failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive cardiovascular disease  |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| <i>Ē</i> xaminer  | ٦  | Immediate Cause (Final disease<br>or condition resulting in death)   |                                       |                      |                   | ascular                 | disea   | ase         |                         | -                       |   |  |  |
|   |  | Sequentially list conditions.  b.  |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
|   | Ē  | if any, leading to immediate   | Due to (or as a c                     | onsequence of        | ):                |                         |   |             |                         |                         | 1.0   |  |  |
| -   | 힐  | cause. Enter Underlying Cause (Disease or injury that initiated  | C.                                    |                      |                   |                         |   |             |                         |                         |   |  |  |
| red<br>nsit   | Ä  | events resulting in death) Last  | Due to (or as a c                     | of isequenice or     | 1.                |                         |   |             |                         |                         |   |  |  |
| xecuted<br>n and<br>I - transit   | /Medical Examiner  | X UNPENDED   | d                                     |                      | -                 |                         |   | -           |                         |                         |   |  |  |
| 760,<br>cate be ex<br>physician<br>the burial   | ğ  | IF FEMALE:   | 23a                                   | ,27,pe               | rmE, g            | 902 4/2                 | 7/10  | TT          |                         | 23d. Date of            | delivery  |  |  |
| 8760, ifficate be ng physic is the bur  | 2  | 23b. Was decedent pregnant in t  |                                       | itcome of pregr<br>h | ancy Feta         | al death 3              | Ectopic   | c pregnanc  | у                       | Month                   | Day Year  |  |  |
| Box 68<br>death certif<br>he attending<br>d for use as  | icia   | past 12 months?  | 4 Pregnar                             | nt at time of dea    |                   | er (Specify)            |   |             |                         |                         |   |  |  |
| P.O. Box 687 s that the death certific gned by the attending I e detached for use as the  | Physician  | 1 Yes 2 No 9 Ur  | known 9 Unknow                        | 'n                   |                   |                         |   |             |                         |                         |   |  |  |
| P.O. es that the igned by   | by P   | Part II. Other significant condi   | tions contributing to c               | leath but not re     | sulting in the un | derlying cause          | given in Pa   | art I.      |                         |                         | bute to the cause of death?                                       |  |  |
| signe start   | D D  |  |                                       |                      |                   |                         |   |             | 1Yes                    |                         | Probably 4 🗹 Unknown  |  |  |
| cords,<br>law requir<br>has been s  | ete  |  |                                       |                      |                   |                         |   |             | 24a. Was at autops      |                         | Vere autopsy findings available<br>rior to completion of cause of |  |  |
| Reco<br>The law<br>icate has  | Completed  | performed? death?  |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| tal Re  |  |  |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| Vital I<br>hysician:<br>this certifi<br>I director,   | o Be   | examiner? Hospital:   Langington 2   ED/Outputiest 2   DOA   Other,   Nursing Home 5   Registeres 6   Other S  |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be  | -  | 72 Manager of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred   |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| ion of tending Pheath.  | 힐  | 1   Natural   5   Pending   Investigation   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Number or Rura or Town, State)   1   Yes 2   No     1   Yes 2   No   1   Yes 2   No   1   Yes 3   No   1   Yes 4   No   Yes 4   Yes 4   Yes 5   No   Yes 5   Yes 6   Yes 6   Yes 7   Yes 7   Yes 8   Yes 8   Yes 8   Yes 8   Yes 9   Ye   |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| iSic<br>r Atte<br>er der<br>recto   | ica  |  | estigation 28e. Place                 | of Injury - At ho    | me, farm, street  | , factory, office       | factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City |             |                         |                         |   |  |  |
| Divisic<br>the Hospital or Atte<br>hin 24 hours after dea<br>the Funeral Directo  | E  | Juiciac  | Id not be ermined (Specify)           |                      |                   |                         |   |             | or Town, Sta            | ate)                    |   |  |  |
| Hospi<br>4 hou<br>Fune<br>ely fi  |  | 00- 0-46-4   | hysician: To the best                 | of my knowledg       | e, death occurre  | ed at the time, of      | date and pla  | ace, and du | e to the cause          | (s) and manner          | as stated.  |  |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical  |  | miner:On the basis of                 | examination ar       |                   |                         |   |             |                         |                         |   |  |  |
| To with   | ğ.   | 29b. Signature and title of certifi  | and manner sta                        | ieu.                 |                   | 29c. Licen              | se number   |             |                         | 29d. Date signe         | ed (Month, Day, Year)   |  |  |
|   |  | D-4)   | 100                                   |                      |                   | 0.0                     | .M.E.   |             |                         | April 14, 20            | 10  |  |  |
| MAN   |  | 30. Name and address of person   |                                       | of death (Item       | 23a)              |                         |   |             |                         |                         |   |  |  |
| D HM  |  | Donna M. Vincenti, M   |                                       |                      |                   | Penn Stree              | t, Baltimo  | ore, MD     | 21201                   |                         |   |  |  |
|   | tate   | 31. Date filed (Month, Day, Year)  |                                       |                      |                   |                         |   |             |                         |                         |   |  |  |
| Regis   |  |  | Lù TO KOH)                            | strar's Signatu      | My . M.           | Dave                    |   |             |                         |                         |   |  |  |

| _                            |  |   | 1 - State<br>Registrar   |  | Cer  | rtificate of   | Death   |  | leg. No.   |   |  |  |
|------------------------------|--|---|--|--|--|--|---|--|--|---|--|--|
| Ε                            | Physici  | an  | 1. Decedent's Name (First, Middle, La.<br>Hubert Aldine Bra  |  |  |  |   | 2. Date of Dea<br>Month  | Day Year   | 3. Time of Death  Q:58 P M  |  |  |
| 2                            | /Medio   |   | 4a. Facility Name (If not institution, giv   |  |  | 4b. City, Town, o  | r Location of Death   | PAPRIL   | 12 2010<br>4c. County of Dea   | 5 2.00  |  |  |
|                              | F)   |   | Western Marylan  |  |  | _  | erstown   |  | Washir   |   |  |  |
|                              | Funeral<br>Director  |   | 5. Social Security Number 6. S 220–18–3384 1  Usual Residence of Decedent  |  | rs. last birthday)<br>85 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs. Hours Min.   | 8. Date of Birth<br>(Month, Day<br>March   | 6,1925 Ma  | thplace (State or Foreign<br>ountry)<br>ryland  |  |  |
|                              | /land<br>low   |   | 10a. State 10b. County   | 10c.   | City, Town or Lo   | cation   |   |  | 10d. Inside City Limits  |   |  |  |
| :                            | e Man<br>ta-f sh<br>tified   | ctor                                      | Maryland Washington  | on County Ha   | agerstown  | n  |   |  |  | 1 □Yes 2 No   |  |  |
| :                            | ath with th<br>23a or 28<br>ust be no  | ral Director                              | 10e. Street and Number 500 Northern Ave  | •  |  | 10f. Zip Code 21742  |   |  | 10g. Citizen of What Country? U.S.A.   |   |  |  |
| 980                          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral                                | 11. Maritał Status  1 X Never Married 2  Married 3  Widowed 4  Divorced  | 12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:   |  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🌠 No  | lispanic Origin? (Span, Mexican, Puerto<br>Specify:   | ecify Yes or No-<br>Rican, etc.)   | 14. Race - Am<br>Black, Whi  | te, etc.  |  |  |
| 20                           | "natur   | Completed                                 | 15. Decedent's Ed<br>(Specify only highest gra   | ducation<br>ade completed)   | 16a. Deced   | dent's Usual Occup   | ation<br>during most of work<br>d)  | ing  | 16b. Kind of Business  | s/Industry  |  |  |
| 12                           | within<br>iene.<br>than<br>the Me  | dwo                                       | Elementary/Secondary (0-12)  | College (1-4or 5+)   |  | essor  | 1)  |  | Universit  | .v  |  |  |
| and 2                        | d be filed<br>intal Hyg<br>ied other<br>sevent, i  | Be  | 17. Father's Name (First, Middle, Last, Clay K. Brandenb   |  |  |  |   | , ,  | Maiden Surname)<br>Brandenbur  |   |  |  |
| Maryland 21215-0036          | d 2 shoulk<br>th and Me<br>7 is mark<br>traumatic  | <u>م</u>                                  | 19a. Informant's Name/Relationship ( Dennis Brandenbu  | Type. Print)   |  |  | and Number or Run   | al Route Numbe   | r, City or Town, State,  | Zip Code)   |  |  |
| ore, I                       | ges 1 and<br>t of Healt<br>If item 2<br>or other   |   | 20a. Method of Disposition 1 X Buriał 2 □ Cremation 3 □  | 201  | b. Place of Disport<br>cemetery, cren  | sition (Name of<br>matory or other plac  | ce)   | Date   | 20c. Location - City o   | r Town, State   |  |  |
| Baltimore,                   | ermit. Pa<br>spartmen<br>portant:<br>y Injury  |   | 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licentary 1.1. Signature 0.1. Signat  |  |  | en Cemete  2. Name and Addre   |   |  | Hagerstown<br>. Fiery Fu   |   |  |  |
| _                            | 9 9 E 8 9  |   | / Dunger 7   | 7 trung  |  |  |   |  | agerstown,   |   |  |  |
| F                            | Physician  |   | 23a. Part1. Enter the disease, or com<br>shock, or head ailure. List only<br>Immediate Cause (Final<br>disease or condition  | one cause on each line.  PULMONA   |  | ETHE MODE OF CLUS  |   | or respiratory ar  | rest,  | Approximate Interval Between Onset and Death WEEKS  |  |  |
|                              | /Medical<br>Examiner   |   | resulting in death)  | Due to (or as a cons   | sequence of):  |  |   |  |  | WEEKS   |  |  |
| 7                            | ed sit   | niner                                     | Sequentially list conditions, if any, leading to influentate cause. Enter Underlying Cause (Disease or injury  | b. Due to (or as a cons  |  |  |   |  |  | 116623  |  |  |
| ,<br>00                      | e executivian and urial-tran   | I Examiner                                | that initiated events resulting in death) Last   | Due to (or as a cons   | sequence of):  |  |   |  |  |   |  |  |
| 68760,                       | ficate to physic some by the post  | edical                                    |  | ►d   |  |  |   |  |  |   |  |  |
| P.O. Box                     | the death certi:  / the attending ched for use a   | Physician/Me                              | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?   | 23c. If yes, outcome pf pre  |  |  |   |  |  |   |  |  |
| A .                          |  | 2   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 1 ☐ Live birth 2 ☐ F<br>4 ☐ Pregnant at time<br>9 ☐ Unknown  | Fetal death 3  | Ectopic pregnance Other (specify)  | /   |  | 23d. Date of de<br>Month   | elivery<br>Day Year   |  |  |
| ds, F                        | uires that<br>signed b<br>d be deta  |   | 9 ☐ Unknown  Part II. Other significant conditions of  | 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown  contributing to death but not   | Fetal death 3 Coff death 5 Coff death 5 Coff death 5 Coff death 1 Coff | Other (specify)  |   | 23e. Did to  | Month  | Day Year  |  |  |
| cords, F                     | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit  |   | 9 Unknown Part II. Other significant conditions of   | 1 Live birth 2 Fregnant at time 9 Unknown  | resulting in the ur  | Other (specify)  |   | 1 🗆 Y  | Month  bacco use contribute  'es 2 ★No 3 □ F   | Day Year  to the cause of death?  Probably 4 □Unknown   |  |  |
| al Records, F                | The la<br>ate has<br>page 2  | Completed by                              | 9 Unknown Part II. Other significant conditions of CEREBROVASCO  | 1 Live birth 2 Fregnant at time 9 Unknown  | resulting in the ur  | Other (specify)  | en in Part I.   | 1  Yasa autop perfo  | Month  bacco use contribute fes 2 No 3 □ F  an 24b. Were a priorite trined? 2 No 1 □ Ye  | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available ocompletion of cause of   |  |  |
| Vital Records, F             | The la<br>ate has<br>page 2  | Be Completed by                           | 9 Unknown  Part II. Other significant conditions of CEREBROVASCOMMOCAR DIAL  25. Was case referred to medical examiner?  | 1 Live birth 2 Fregnant at time of Unknown  contributing to death but not WLAR ACCION  | resulting in the un  | Other (specify)  | en in Part I.   | 1 □ Y  24a. Was autop perfo  1□ Yes  h (Check only o   | Month  bacco use contribute  (es 2 No 3 F  an 24b. Were a prior to death? 2 No 1 Vene)   | Day Year  to the cause of death?  Probably 4 □Unknown autopsy findings available ocmpletion of cause of   |  |  |
| or Vital Records, F          | The la<br>ate has<br>page 2  | To Be Completed by                        | 9 Unknown  Part II. Other significant conditions of CEREBROVASCOMMOCAR DIAL  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death  | 1   Live birth 2   F 4   Pregnant at time 9   Unknown    contributing to death but not   LAR   CC    INFARCTION    Hospital: 1   Inpatient   28a. Date of Injury   | resulting in the ur  CIDENT  N  EINER/Outpatien  28b. Time of  | Other (specify)  | en in Part I.  26. Place of Deater: 4 🛭 Nursing Ho  | 1  Y  24a. Was autop perform 1 Yes h (Check only one)  | Month  bacco use contribute fes 2 No 3 □ F  an 24b. Were a priorite trined? 2 No 1 □ Ye  | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available ocmpletion of cause of  |  |  |
| sion or Vital Records, F     | The la<br>ate has<br>page 2  | To Be Completed by                        | 9 Unknown  Part II. Other significant conditions of CEREBROVASCO  MYOCAR DIAL  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  | 1   Live birth 2   F 4   Pregnant at time 9   Unknown    contributing to death but not    LAR   CC    INFARCTION    Hospital: 1   Inpatient   2    28a. Date of Injury (Month, Day Year  | resulting in the ur  CIDENT  N  CER/Outpatien  28b. Time of Injury   | Other (specify)  Inderlying cause give  The specify of the specific of the specifi | en in Part I.  26. Place of Deater: 4 🛭 Nursing Ho  | 1  Y  24a. Was autop perform 1 Yes h (Check only one)  | Month  bacco use contribute  yes 2 No 3 F  an sy prior to death? 2 No 1 Vene  ne)  | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available ocmpletion of cause of  |  |  |
| Division or Vital Records, F | The la<br>ate has<br>page 2  | ertification: To Be Completed by          | 9 Unknown  Part II. Other significant conditions of CEREBROVASCOMY OCAR DIAL  25. Was case referred to medical examiner? 1 Yes 25 No  27. Manner of Death 1. Natural 5 Pending   | Live birth 2 Fregnant at time of Unknown  contributing to death but not ULAR COLUMN ACCUMENTAL ACCU | resulting in the ur  CIDENT  N  PER/Outpatien  28b. Time of Injury  at home, farm, strr.   | Other (specify)  Inderlying cause give  The specify of the specific of the specifi | 26. Place of Deater: 4 💆 Nursing Hove   | 1 □ Y  24a. Was a autop performent of the control o | Month  bacco use contribute  res 2 No 3 F  an sy prior to death? 22 No 1 Vene)  lence 6 Other (Sp. low injury occurred   | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available completion of cause of ss 2 □ No  |  |  |
| Division or Vital Records, F | Hospital or Attending Physician: The la<br>hurs after death.<br>Funeral Director: After this certificate has<br>tely filled in by the funeral director, page 2   | Certification: To Be Completed by         | 9 Unknown  Part II. Other significant conditions of CEREBRO VASCO  MYOCAR DIAL  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural investigation investigation investigation investigation determined  4 Homicide  29a. Certifier  1 Certifying Part   | Live birth   2   F   | resulting in the ur  CIDENT  N  ENOUGH ER/Outpatien  2 Bb. Time of Injury  At home, farm, streecity)  knowledge, death   | other (specify)  | 26. Place of Deat er: 4 ፟   | 24a. Was a autop performent of the performance of t | Month  Display to the property of the property | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available of completion of cause of security)  Bural Route Number,  as stated.                        |  |  |
| Division or Vital Records, F | or Attending Prysician: The la<br>lifer death of Director: After this certificate has<br>in by the funeral director, page 2  | ertification: To Be Completed by          | 9 Unknown  Part II. Other significant conditions of CEREBROVASCOMMYOCAR DIAL  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1. Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  | 1 Live birth 2 F4 APregnant at time of SUnknown  Contributing to death but not CLAR ACCION FARCTION  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year building, etc. (Springs))  28b. Place of injury - A building, etc. (Springs)  1 and manner stated.   | resulting in the ur  CIDENT  N  ENOUGH ER/Outpatien  2 Bb. Time of Injury  At home, farm, streecity)  knowledge, death   | nt 3 DOA Other (specify) on the specify) of the specify of the specify of the specify of the specific of the s | 26. Place of Deat er: 4 M Nursing Ho y at k? Yes 2 No me, date and place, ppinion, death occur                        | 24a. Was a autop autop yes h (Check only o. me 5 Reside 28d. Describe h 28f. Location (Saturday or Town and due to the red at the time,  | Month  Display to the property of the property | Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available completion of cause of s. 2 No  ecify)  Bural Route Number, as stated. Je to the cause(s)     |  |  |
| Division or Vital Records, F | Hospital or Attending Physician: The la<br>hurs after death.<br>Funeral Director: After this certificate has<br>tely filled in by the funeral director, page 2   | edical Certification: To Be Completed by  | 9 Unknown  Part II. Other significant conditions of CEREBROVASCO  MYOCAR DIAL  25. Was case referred to medical examiner? 1   Yes   2 No  27. Manner of Death 1 Natural   5   Pending investigation investigation of University of the Could not be determined.  29a. Certifier (Check only one)   | 1 Live birth 2 F4 APregnant at time of SUnknown  Contributing to death but not CLAR ACCION FARCTION  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year building, etc. (Springs))  28b. Place of injury - A building, etc. (Springs)  1 and manner stated.   | resulting in the ur  CIDENT  N  ENOUGH ER/Outpatien  2 Bb. Time of Injury  At home, farm, streecity)  knowledge, death   | nt 3 DOA Other (specify) on the specify) of the specify of the specify of the specific of the  | 26. Place of Deat er: 4 \text{ Nursing Ho} yat k? Yes 2 \square No me, date and place, opinion, death occur ie number | 24a. Was a autop performent of the performance of t | Month  bacco use contribute  ces 2 No 3 F  an sy 24b. Were a prior to death? 22 No 1 Vene)  lence 6 Other (Sp low injury occurred  cause(s) and manner adate and place, and divided and place.  | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available of completion of cause of the secify)  Bural Route Number,  as stated.  Let to the cause(s) |  |  |
| Division or Vita             | To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2  | Medical Certification: To Be Completed by | 9 Unknown  Part II. Other significant conditions of CEREBROVASCOMMOCAR DIAL  25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only one) 1 Certifying Processing Check only one) 2 Medical Example 29b. Signature and title of certifier Management of the condition of the certifier Management of the certifier of the certi | Hospital: 1   Inpatient 2   Page 2   Page 3   Pa | resulting in the ur  CIDENT  REPLACE STATE OF THE STATE O | other (specify)  nderlying cause give  to a 3 DOA Other  M 28c. Injuny Wor 1 Correct, factory, office  the occurred at the timestigation, in my office  29c. Licens  DO O  Print)  | 26. Place of Deather: 4 Manusing Hory at k? Yes 2 No me, date and place, opinion, death occur is number 6 2 8 9 5     | 24a. Was a autop point of the control of the contro | Month  bacco use contribute  fes 2 No 3 F  an sy prior to death? 22 No 1 Vene  an prior to death? 22 No 1 Vene  fene 6 Other (Sp.  forwinjury occurred  cause(s) and manner adate and place, and divided and place, and divided and place.   | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available of completion of cause of the secify)  Bural Route Number,  as stated.  Let to the cause(s) |  |  |
| Division or Vita             | Hospital or Attending Physician: The la<br>hurs after death.<br>Funeral Director: After this certificate has<br>tely filled in by the funeral director, page 2   | Medical Certification: To Be Completed by | 9 Unknown  Part II. Other significant conditions of CEREBROVASCOMYOCAR DIAL  25. Was case referred to medical examiner? 1   Yes   22 No  27. Manner of Death 1 Natural   5   Pending investigation   2   Accident   3   Suicide   4   Homicide   6   Could not be determined    29a. Certifier (Check only one)   1   Certifying Proceedings   Certifier   Medical Examination   1   Certifying Proceedings   1     Certifying Proceedings   1     Certifying Proceedings   1  | Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28b. Place of injury - A building, etc. (Spinner: On the basis of examand manner stated.  | resulting in the ur  CIDENT  REPLIED TO THE PROPERTY TO THE PR | other (specify)  nderlying cause give  to a 3 DOA Other  M 28c. Injuny Wor 1 Correct, factory, office  the occurred at the timestigation, in my office  29c. Licens  DO O  Print)  | 26. Place of Deat er: 4 \text{ Nursing Ho} yat k? Yes 2 \square No me, date and place, opinion, death occur ie number | 24a. Was a autop point of the control of the contro | Month  bacco use contribute  fes 2 No 3 F  an sy prior to death? 22 No 1 Vene  an prior to death? 22 No 1 Vene  fene 6 Other (Sp.  forwinjury occurred  cause(s) and manner adate and place, and divided and place, and divided and place.   | Day Year  to the cause of death?  Probably 4 □Unknown  autopsy findings available of completion of cause of the secify)  Bural Route Number,  as stated.  Let to the cause(s) |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apr. 1 Physician/ Samuel 2010 Dorsey Beaslev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Memorial Hospital Easton Easton Birthplace (State or Foreign Country)
 Ga. If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 04-20-1937 1 **X**M 2 □ F Director 219-34-3288 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at anoine. 10c. City, Town or Location 10b. County Director Federalsburg Md Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Seasley, by Funeral 602 Federalsburg Manor 21632 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACME 12 Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorsey Rufus Luberta Trene Jordan <u>Beasley</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23rd St., Wilmington, De. 19802 <u>Joyce Sanders /Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-09-10 Preston, Maryland Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Maryland 21601 ammie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS ⊈hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate oause. E. ner Underlying Cause (Disease or linjury INFECTION URINARY TRACT Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be 2 No ျ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) D66441 APRIL 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET EASTON MD 2195 WASHINGTON BOLLI RAMESH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

1810

10d. Inside City Limits

Approximate Interval Between

Onset and Death

DAYS

DAYS

2010

21601

Black

1 XYes 2 No

DHMH 17 Rev 7/2009

State

Registrar

APR 0 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12550 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month <sup>Day</sup> 2010 Physician/ 7:20 A April David Rudolph Byington Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 55 Regatta Bay Ct., Apt. Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 □ F Months Days Hours 1076/1938 Ok lahoma Director 443-38-5901 Yrs. 71 Usual Residence of Decedent filed within 72 nous access tall Hygiene and other than "natural", or items 23a or 28a-f show or other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 Regatta Bay Ct., Apt. 255 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc. American Armed Forces?

1 X Yes 2 No ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 1955-59 Indian 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Indian Health College (1-4 or 5+) Elementary/Seconday (0-12) years Program <u>Analyst</u> other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of ည Ellen Taylor David Byington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st
Department of Health a
Important: If item 27 is
any injury or other tra 3025 Rock Drive, Riva, Maryland 21140 Denise E. Lundberg/ Daughter 20a. Method of Disposition
1 ☐ Burlal 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 4/2/10 Kalas Crematory Edgewater, MD And al Sevige Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Leu Kemia inte Physician/ mos disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No ate has been signed by the a page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\boxtimes$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA e Hospital or Attending Ph 124 hours after death. e Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifler Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00047348 30. Name and address or person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 21287 MP 1650 orleans Sweet Room 246 Douglas Smith

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

istrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 12:58 PM April Courtenay W. Bass /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel 1302 River Crescent Drive Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days Min. Months Hours 466-26-6799 1 □ M 2/5/F Yrs. 87 Feb. 8, Texas Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State in than "natural", or Items 23a or 28a-f show the Medical Exeminar must be notified at Anne Arundel Annapolis Maryland 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1302 River Crescent Drive 21401 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation parmit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, Ins Meuls 00028. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Librarian 5+ 17. Father's Name (First, Middle, Last)
William Franklin Wright 18. Mother's Name (First, Middle, Maiden Surname) Be Cliffie Hood ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) R. William Bass/husband 1302 River Crescent Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore Crematory 4/8/2010 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur - Juneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GLIOBLASTOMA mus Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of): ad by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signad by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 24 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home & Residence 6 Other (Specify) 1 ☐ Yes 27 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending 1 Alatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 D08118 1/and Suc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMMMUZIS MATIGINS mo 900 BBST6ATE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per phys. G902 4722/10 Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year April 11, Mary Louise Bender Medical 9:00 A Facility Name (if not institution, give street and number)
Goodwill Mennonite Home Examiner 4b. City, Town, or Location of Death 4c. County of Death Grantsville Garrett Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔽 F Days Hours 01/30/1938 Months Salisbury. Director Yrs 163-32-1767 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 163 Stockyard Road 21520 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer N. Hershberger Fannie E. Beachy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Bender / Daughter <u> 2 Box 74. Accident. MD 21520</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WVU Memorial Vault 04/11/2010 | Morgantown, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WVU Human Gift Registry Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as 2 Weeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsv Hospital or Attending Physician: The certificate 1 Tes 2 No ☐ Yes 2 🛣 No Division of Vital funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛛 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

Om

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Muhammad Naeem, MD, 625 Kent Avenue, Cumberland, MD 21502

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sherman Burton, Jr. 2010 Medical Apri1 945 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12717 Indian Springs Road Big Pool Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) June 09, 1935 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Hours Min. Country) Director 218-30-8926 74 Yrs MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD Big Pool Washington 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12717 Indian Springs Road 21711 USA death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married δ 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: "natural", Completed 3 Divorced 4 Divorced White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. לא is marked איני Elementary/Seconday (0-12) College (1-4 or 5+) Trackman Western MD.Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Sherman S. Burton, Sr. Grace Viola Walls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Judith A.Burton/wife 12717 Indian Springs RD Big Pool, MD 21711 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place injury 4 ☐ Donation 5 ☐ Other (Specify) Parkhead Cemetery 04/12/2010 Big Pool, MD 21. Sonatury of Funera 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death Lbrovarula Medical resulting in death) Examiner Subia huclean Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of): Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months? Pregnant at time of death Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Winknown peen 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death? autopsy performe 2 No Yes 2 N 1 Yes 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) . Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work' 1 Yes Accident 2 No Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 190 mr LO AD MEMBERNA ma HETWA & HMM 31. Date filed (Month, Day, Year) State Registrar DHMH III Rev 7/2009

ORIGINAL

10-02950 Novella Curtis

| Ple | State of Maryland / Department of Health and Mental Hygiene |      |
|-----|---|------|
|     | State of Maryland / Department of Health and Mental Hygiene | 1255 |
| •   | Certificate of Dooth  |      |

|  |              | 1- For State Registrar   | Certificate of                            | Death   |  | Reg. No.   |   |
|--|--------------|--|---|---|--|--|---|
| Physicia<br>Medical Examir   |              | Decedent's Name (First, Middle, Last)  |   |   | ath<br>Day Year                                | 3. Time of Death                                       |   |
| Medical Examin   | iei          | /***********************************   |   | b. City, Town, or Location of I                               | April 15, 2                                    | 2010   | 0930 hrs                                      |
|  |              | 43 Facility Name (if not institution, give street and number) COASTAL HOSPICE ON THE LAKE Deers Head Hospice on the Lake   | •   | Salisbury   | Jean   | 4c. County of Death                                    |   |
| Funeral  |              | 5. Social Security Number 6. Sex 7. Age  | (In yrs. last birthday)                   | If Under 1 Year If Under 2                                    | 24Hrs. 8. Date of Bi                           | rth(MM/DD/YYYY) 9. Bir                                 |   |
| Director   |              | 214-32-6393 1 M 2 MF 9   | Yrs.                                      | Months Days Hours   | Min.   | Foreign  |   |
|  |              | Usual Residence of Decedent  |   |   |  | 11, 1110   | mo,   |
| w an)  |              | ,  | IOc. City, Town or Location               | on  |  |  | 10d. Inside City Limits                       |
| yland<br>f sho   | 후            | Maryland SomerseT  | Princess                                  | Anne  |  |  | 1 Yes 2 No                                    |
| or death with the Maryland<br>or items 23a or 28a-f show any<br>must be notified at once.  | Director     | 10e. Street and Number   | 101                                       | 10f. Zip Code   | 1  | 0g. Citizen of What Cou                                | ntry?   |
| ith the  |              | 11230 Green wood School  11. Marital Status 12. Was Decedent E   |   | 21853   |  | U.S.A.   |   |
| eath w<br>items  | uneral       | 1 Never Married 2 Married Armed Forces?  | If Ye                                     | Decedent of Hispanic Origin'<br>s, specify Cuban, Mexican, Po | ? ( Specify Yes or No<br>uerto Rican, etc.)    | 14. Race - Ameri<br>White, etc.                        | can Indian, Black,                            |
| fter de l'', or  | ᄔᅵ           | 3 Widowed 4 Divorced If Yes, Give Year   | ☑ No I                                    | Yes 2 No specify:   |  | Specify: Bla   | . K   |
| ours a atura   | d b          | 15. Decedent's Education (Specify only highest grade comp  | leted) 16a. Decedent's                    | s Usual Occupation (Give kind                                 | d of work done                                 | 16b. Kind of Business/I                                |   |
| 6<br>n 72 h<br>an "n<br>ical E   | Completed    | Elementary/Secondary (0-12) College (1-4 or 5+   | ')   .                                    | st of working life. DO NOT use                                | e retired)                                     |  | _   |
| withi<br>withingiene.  | Ē            | 8th grade<br>17. Fathers Name (First, Middle, Last)  | Lai                                       | borer   |  | Produce  | tactory                                       |
| 115-<br>e filed<br>al Hyg<br>ed off  | Be C         | John Samuel Jones  |   | i   | iame (First, Middle, I                         | Maiden Surname)  |   |
| 212<br>212<br>Ment Ment<br>mark  | 일            | 19a. Informant's Name/Relationship (Type, Print )  | 19b. Mailing A                            | Address (Street and Number                                    | or Rural Route Nun                             | nber, City or Town, State                              | Zin Code)                                     |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once   |              | Wendell Curtis- Son  | 310                                       | 48 Eden Al  | len Rd.  | Eden mel   | 21833   |
| Te, Land I and Theal Theal   | ı            | 20a. Method of Disposition   | 20b. Place of Dispositi crematory or othe | on (Name of cemetery,   | Date   | Eden Md<br>20c. Location - City or                     | Town, State                                   |
| Pages<br>lent of<br>unt: I   |              | 1 \textbf{Y} Burial 2 \textbf{Cremation} Cremation 3 \textbf{Removal from State} 4 \textbf{Donation} 5 \textbf{Other Specify:}   | M+ Hope Ch                                | och Constant  | 4/23/10  | Princess   | Appe ml                                       |
| Baltimore,<br>permit. Pages I an<br>Department of Hea<br>Important: If iter  | ŀ            | 21. Signature of Funeral Service Licensee  | 22. Na                                    | me and Address of Facility                                    | Anthonie                                       | interest Fr  | 1.  |
|  | $\dashv$     | Anthon E. Would Jr.  | 30  | vech Cemetery<br>me and Address of Fadlity<br>639 Hampde,     | 1 Ave.   | Princess An  | ne, md 2,853                                  |
| Physician /Medical   | 1            | 23a. Part I. Enter the disease, or complications that caused the<br>failure. List only one cause on each line.   | e death. Do not enter the                 | mode of dying, such as cardi                                  | ac or respiratory arre                         | est, shock, or heart                                   | Ápproximate Interval<br>Between Onset and     |
| Examiner   | -            | Immediate Cause (Final disease or condition resulting in death)  |   | is  |  |  | Death   |
| - 1  | -            | Ilrinary tr  | ,   | on and decubi   | us ulcers                                      | 3  |   |
| Š  | ē            | If any, leading to immediate Due to (or as a consequ   |   |   |  |  |   |
|  | Examiner     | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    C. Due to (or as a consequence of the consequen | ience of):                                |   |  |  |   |
| xecuted n and - transit  |              | d.   | 101,00 017.                               |   |  | 1  |   |
| 9 5 5  | Medical      | X AMENDED X AMENDED PI   | ine a-,                                   | , per<br>903 5/19/10 т  | 11/1/10 1                                      | T  |   |
| 760, icate be ex physician the burial  | ĔĹ           | IF FEMALE: 23c. If yes, outcome  | of pregnancy                              | 303 3/13/10 T   | 1  | 23d. Date of delivery                                  |   |
|  |              | 23b. Was decedent pregnant in the past 12 months?  | ne of death                               | death 3 Ectopic pre   | egnancy  | Month D  | ay Year                                       |
| Box 68 e death certif the attending ed for use as  | Physician    | 1 Yes 2 No 9 Unknown 9 Unknown   | of death 5 Other                          | (Specify)   |  |  |   |
| . 4 54 7   |              | Part II. Other significant conditions contributing to death b  | ut not resulting in the und               | lerlying cause given in Part I.                               | 23e. Did to                                    |  | ne cause of death?                            |
| rds, P.C   | <u>0</u>     |  |   |   | 1Yes   | 2 No 3 Proba   | ably 4 Unknown                                |
| ords   | Completed    |  |   |   | 24a. Was a                                     |  | opsy findings available ompletion of cause of |
| Recol The law cate has page 2 sh   | Ē            |  |   |   | perform  | med? death?  |   |
| Division of Vital Records, P.O tat or Attending Physician: The law requires that the state death.  at Director: After this certificate has been signed by the funeral director, page 2 should be detachting the former of the property of | ارہ          | 25. Was case referred to medical examiner?   |   | 26.Place of Death (Che  |  |  |   |
| Vit<br>hysic<br>this o   | <u>n</u>     | 1 Yes 2 No   | 2 ER/Outpatient 3                         | DOA Other Nu  | rsing Home 5 1                                 | Residence 6 🗸 Other:                                   | Scene   |
| ding Ph  |              | 27. Manner of Death  28a. Date of Injury (Month, Day, Year)  | 28b. Time of Inju                         |   | 28d. Describe h                                | ow injury occurred                                     |   |
| Sior Attend  | gati         | 2 Accident Investigation   |   | 1 Yes 2 No  |  |  |   |
| Divi:  | 21           | determined (Specify)   | / - At home, farm, street, f              | factory, office building, etc.                                | 28f. Location (Son Town, St                    | treet and Number or Rura<br>ate)                       | al Route Number, City                         |
| y fill   | - ا د        | Homicide (Special)   | anuladas dosth sesures                    | l at the time of the send of the                              |  |  | <del></del>                                   |
| Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,  |              | one) 2 Medical Examiner: On the basis of examin  | ation and/or investigation                | , in my opinion, death occurre                                | and due to the cause<br>ed at the time, date a | e(s) and manner as stated<br>and place, and due to the | cause(s)                                      |
| To To  | <u>ē</u>   2 | and manner stated.  29b. Signature and title of certifier  |   | 29c. License number   | _  | 29d. Date signed (Mont                                 | h, Day, Year)                                 |
|  |              | D_100_ n   |   | O.C.M.E.  |  | April 16, 2010   |   |
|  | 3            | 30. Name and address of person who completed cause of deat   | h (Item 23a)                              |   |  | -  |   |
|  |              | Donna M. Vincenti, MD Assistant Medical  |   | enn Street, Baltimore,  | MD 21201                                       |  |   |
| Stat<br>Registra   | _            | APR 8 0 2010 Registrar's S   | Signature                                 | 7   |  |  |   |
| DHMH 17 Rev 1/200  | _            | nin a v colo perma   | p. gara                                   |   |  |  |   |
| OCME 2008  | 1            |  | ORIGINAL                                  |   |  |  |   |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Ruth M. Chambers April 9. 2010 12:10A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Bowie Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 29, 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√ F 1926 PA 579 26 8470 84 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show at a or 28a-f shot be notified a Director Maryland Prince George's 1 ☐ Yes 2 ☐ No Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3503 Lottsford Vista Road 'natural", or items 23a **Examiner must** 20721 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 XWidowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than ' Elementary/Secondary (0-12) 12 College (1-4or 5+) Statistician Census 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy C. Simpson Matilda Litner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau Donna Chambers (Daughter) 3503 Lottsford Vista Road, Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory April 10, 2010 Clinton, Maryland 21. Signature Funeral Mice Ligenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Physician/Medical the attending phase as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 ☐Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2: autopsy certificate performed Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only on 2**17** No Other: 1 TYes Certification: To 1 | Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred t Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by completely

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 GALLANT FOXLN #1222

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 Wells Clifford April 9:25P Susan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 4108 Rosemary Street Chevy Chase If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, Year) SC 25, 1922 1 🗆 M 2 💢 Months Days Hours Min. Switzerland Director 87 30-24-3951 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4108 Rosemary Street 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🐼 No Specify: Specify: 3 Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u> Artist</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Sweetser Ruth permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marks any injury or other traumatic Gregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia A. Clifford/daughter 316 Pine Street Helena, Montana 59601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burlal 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/8/2010 Woodbine, Maryland 21. Sign two of Funeral Service Lip 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
| Beverly L. Heckrotte, P.A. Clarksville, M M00957 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pleural Effusion Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine and I-transit Physician; The law requires that the death certificate be executed Pancreatic Cancer Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 2 XNo 9 Unknown a Unknown Division of Vital Records, P.O. ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2X No 2 🗌 No 1 Yes Be 25. Was case referred to medical director, 26. Place of Death (Check only one) Hospital 2 XNo Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending iniury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0044025 April 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Linda M. Thompson, 8218 Wisconsin Ave., Suite 215 Bethesda, Maryland 20814 M.D.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 09

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April 4:44 ELIZABETH CRAVEN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Frederick Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min Months Mary Land **Director** 213-18-9856 89 1920 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Jefferson 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4147 Lander Road 21755 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ై Thomas Lakin Thrasher Cordelia Summers 19a. Informant's Name/Relationship (Type, Print) Thomas F. Craven, son 4147 Lander Road, Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery April 21, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service License 22. National Home 22. National Particle M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last s a consequence Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death
Unknown Day 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has build inector, page 2 s autonsy 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier llander nehime -15-2010 MDD 64910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pratima Pande 400

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Menth, Day, Year)

| 10-02567<br>Randolph Josep   |                | Please Type of State 1- For State Registrar   | or Print in Black<br>of Maryland / D   | k Indelible I<br>epartment o<br>Certificate o | Ink. Ensu<br>of Health a<br>of Death | ure All Copic<br>and Mental H             |                                | egible.<br>201   | 0   255   |
|--|----------------|---|--|---|--------------------------------------|---|--------------------------------|--|---|
| Physicia<br>Medical Exami  |                | Decedent's Name (First, Middle,La Randolph Joseph   |  | 'n  |                                      |   | 2. Date of Dea<br>Month        | Day Year   | 3. Time of Death  |
| )  |                | 4a. Facility Name (if not institution, give 410 Patrick Avenue                                  |  | , .   | 4b. City, Town,<br>Salisbury         | or Location of Death                      | April 1, 20                    | 4c. County of De<br>Wicomico   |   |
| Funeral<br>Director  |                | 5. Social Security Number 6. S 216–56–2142  | 7. Age (In   | yrs. last birthday)<br>Yr                     | If Under 1 Y                         | ear If Under 24Hrs Pays Hours Min         | _                              | For  | Birthplace (State or<br>eign<br><sup>Country</sup> Maryland |
| w any  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c.   | City, Town or Loca                            | ation                                |   | 1001-0                         | 1====  | 10d. Inside City Limits                                     |
| ith the Maryland<br>23a or 28a-f show<br>notified at once.   | Director       | Maryland Wicomic  10e. Street and Number  | o S  | alisbury                                      | 10f. Zip Code                        | <del> </del>                              |                                | 10g. Citizen of What C   | 1 X Yes 2 No  |
| the Man or 21 officed  |                | 410 Patrick Ave.  |  |   | 21801                                |   |                                | USA  | ,   |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  | Funeral        | 11. Marital Status 1 Never Married 2 Married  | 11 A Yes 2   | No If Y                                       | Yes, specify Cut                     | Hispanic Origin? ( Spoan, Mexican, Puerto |                                | White, etc   |   |
| ours after a stural" (amine)   | ð              | 3 Widowed 4 Divorced  15. Decedent's Education (Specify of                                      | If Yes, Give Year Army or Dates:   | ed) 16a. Decede                               | Yes 2 X                              | pation (Give kind of v                    | work done                      | Specify: B   | Lack<br>s/Industry  |
| 0036<br>within 72 h<br>iene.<br>er than "n<br>Medical Es   | Completed      | Elementary/Secondary (0-12)   | College (1-4 or 5+)  | Labore  |                                      | ife. DO NOT use reti                      | •                              | none   |   |
| 215-(e filed tal Hygint, the   |                | 17. Father's Name (First, Middle, Last<br>Houston Randolph                                      |  |   |                                      | 18.Mother's Name                          | , ,                            | Maiden Sumame)   |   |
| 213<br>should b<br>ind Men<br>is mar   | 2              | 19a. Informant's Name/Relationship (  | Гуре, Print )  |   |                                      | reet and Number or F                      | Rural Route Nur                | mber, City or Town, Sta  | ate, Zip Code)  |
| e, MI and 2 stealth a item 27  | d              | Marilyn DeShields 20a. Method of Disposition  | 12   | 20b. Place of Dispos                          | sition (Name of                      |   | London ,                       | CT 06320<br>20c. Location - City   | or Town, State  |
| MOF<br>Pages l<br>lent of l<br>unt: If   |                | 1 Burial 2 X Cremation 3 4 Donation 5 Other Specify   |  | crematory or ot<br>Salisbury                  |                                      | orv   4 9                                 | 2010                           | Salisbury  | , Maryland  |
| Balti<br>permit.<br>Departn<br>Imports<br>injury o   |                | 21 Signature of Funeral Service Licer   | nsee   | 22. I<br>St                                   | Name and Addre                       | ess of Facility<br>uneral Ho              | me                             |  | ,                     |
| Physician  | +              | 23a. Part I. Enter the disease, or comp<br>failure. List only one cause on ea                   | olication that caused the d  | FSP 82<br>leath. Do not enter t               | 21 West<br>the mode of dyir          | Rd., Salis<br>ng, such as cardiac o       | hury, M<br>r respiratory arr   | est, slock, or heart   | Approximate Interval  |
| /Medical<br>Examiner   |                | Immediate Cause (Final disease a.   | Hypertensive Athero Due to (or as a consequen                                  |   | iovascular E                         | Disease                                   |                                |  | Between Onset and<br>Death                                  |
|  | اة<br>ا        | Sequentially list conditions, if any, leading to immediate                                      | Due to (or as a consequen  | nce of);                                      |                                      |   |                                |  |   |
|  | amine          | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequen  | nce of):                                      |                                      |   |                                |  | 110   |
| executed<br>an and<br>al - transit   | ũΙ             | d.  |  |   |                                      |   |                                |  |   |
| c be exe<br>ysician  | edic           | UNPENDED  | AMENDED  |   |                                      |   |                                | Tana a de la composição |   |
| Box 68760, e death certificate be the attending physici ed for use as the buri   |                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown              | 23c. If yes, outcome of 1 Live birth 4 Pregnant at time of 9 Unknown           | 2 Fe  | etal death (Specify)                 | Ectopic pregna                            | ncy                            | 23d. Date of delive<br>Month   | ery<br>Day Year   |
| P.O. B<br>s that the d<br>med by the   | 2              | Part II. Other significant conditions   | happend  | not resulting in the u                        | underlying cause                     | e given in Part I.                        | 23e. Did to                    | bbacco use contribute to   | to the cause of death?                                      |
| Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death its after death.  In Director: After this certificate has been signed by the attered in by the funeral director, page 2 should be detached for a  | Completed      |   |  |   |                                      |   | 24a. Was<br>autop              | an 24b. Were a prior to death?   | autopsy findings available ocompletion of cause of          |
| I Re   | S C            | 25. Was case referred to medical  |  |   | 26.Pla                               | ce of Death (Check o                      | 1 Yes                          | 2 No 1 🗸   | Yes 2 No  |
| Vita<br>Physicia<br>r this ce  |                | 1 <b>✓</b> Yes 2 No   | lospital: 1 Inpatient 2  |   |                                      |   |                                | Residence 6 🗸 Oth  | er: Scene   |
| nding P<br>nding P<br>th.  |                | 27, Manner of Death  1  Natural 5 Pending   | 28a. Date of Injury<br>(Month, Day, Year)                                      | 28b. Time of t                                |                                      | ijury at Work?<br>Yes 2 No                | 28d. Describe I                | how injury occurred  |   |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions. | Certification: | 2 Accident Investigati 3 Suicide 6 Could not determined   | be 28e. Place of Injury -  | At home, farm, stree                          |                                      |   | 28f. Location (S<br>or Town, S |  | Rural Route Number, City                                    |
| To the Hosp<br>within 24 hos<br>To the Fune  | edical         | 29a Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner                          | ian: To the best of my know<br>:On the basis of examination and manner stated. |   |                                      |   |                                |  |   |
|  | žΓ             | 29b. Signature and title of certifier   |  |   | 29c. Lice                            | nse number                                |                                | 29d. Date signed (M  | onth, Day, Year)  |

State 31. Date filed (Month, Day, Year)
Registrar APR 0 7

30. Name and address of person w/o complete 1 cau of death (Item 23a)

Jack Titus MD. Deputy Chief Medical Examiner 1 111 Penn Street, Baltimore, MD 21201 32. Degistrar's Signature

ORIGINAL

O.C.M.E.

April 2, 2010

10-02870 Jennifer Dennis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 [2559]

|  | 1- For State Certificate of Death Reg. No.   |  |                                     |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
|--|--|--|-------------------------------------|-----------------------------|-----------------------------|--------------------------------|------------|---------------------|------------|------------------|----------|----------------------|------------------|---|
| Physici<br>Medical Exam  |  | Toppifor Doppig  |                                     |                             |                             |                                |            |                     |            |                  |          |                      | 3. Time of Death |   |
| nedicai Exam   | mer  | 4a. Facility Name (if not institutio   |                                     | umber)                      | Г.                          | 4b. City, To                   | um or Le   | veation of D        |            | pril 12,         |          | c. County of         | Dogth            | 1344 hrs                                      |
|  |  | Baltimore Washington   | -                                   |                             |                             | Glen B                         |            | odilori oi D        | Joann      |                  |          | Anne Arundel         |                  |   |
| Funeral  |  | 5. Social Security Number  | 6. Sex                              | 7. Age (In yrs.             | last birthday)              | If Under                       |            | If Under 2          |            |                  |          |                      |                  | hplace (State or                              |
| Director   | ) i  | 212–37–9355  | 1 M 2 X F                           | 30                          | Yrs                         | Months .                       | Days       | Hours               | Min.       | Feb.             | 11,      | 1980                 | Cou              | Maryland                                      |
| <b>x</b>   |  | Usual Residence of Decedent  |                                     | Lo. or                      | ÷ ;                         |                                |            |                     |            |                  |          |                      |                  |   |
| W an   |  | 10a. State 10b. County  MD Anne  | Arundel                             |                             | , Town or Locati<br>Millers |                                |            |                     |            |                  |          |                      |                  | 10d. Inside City Limits  1 Yes 2 No           |
| Maryland<br>28a-f show any<br>1 at once.   | io   | 10e. Street and Number   |                                     |                             |                             | 10f. Zip C                     | odo        |                     |            | ſ                | 10a Ci   | tizen of Wha         | t Cour           |   |
| s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. | Director   | 8424 Norwood   | Drive                               |                             |                             | 101. Zip C                     |            | 108                 |            |                  | log. Ci  |                      | USA              |   |
| with t<br>ns 23a   |  | 11. Marital Status   |                                     | cedent Ever in U            |                             | s Decedent                     |            |                     |            |                  | 0-       | 14. Race -           | Americ           | can Indian, Black,                            |
| death<br>or iten   | Funeral  | 1 Never Married 2 X Ma   | arried Armed F                      | orces?                      | If Y                        | es, specify (                  | Cuban, N   | /lexican, Pu        | uerto Rica | an, etc.)        |          | White,               |                  |   |
| after<br>ral", o   | by F   |  | orced If Yes, Give Yes<br>or Dates: |                             |                             | Yes 2                          |            |                     |            |                  |          | Specify:             | Whi              |   |
| hours<br>'natu   |  | <ol> <li>Decedent's Education (Special Elementary/Secondary (0-12)</li> </ol>                    | cify only highest gra               |                             | 16a, Deceden<br>during me   | t's Usual Od<br>ost of working |            |                     |            |                  | 16b.     | Kind of Busi         | ness/Ir          | ndustry                                       |
| 36<br>hin 72<br>e.<br>than '   | Completed  | Elementary/Secondary (0-12)  |                                     | 2                           |                             | Home                           | make       | er                  |            |                  |          |                      | Но               | me  |
| 215-0036 be filed within 7 ral Hygiene. Red other than ent, the Medica   | Con  | 17. Father's Name (First, Middle,  |                                     |                             |                             |                                |            |                     |            |                  | Maider   | Surname)             |                  | -   |
| 11215-0036<br>Id be filed within 72 hours after<br>fental Hygiene.<br>aarked other than "natural",<br>event, the Medical Examiner  | Be   | John K. Trader   |                                     |                             |                             |                                |            | Lou A               |            |                  |          |                      |                  |   |
| D 21<br>should<br>and Me   | բ  | 19a Informant's Name/Relations<br>Larry C. Dennis  |                                     | chand                       | 19b. Mailing                | Address<br>Norw                |            |                     |            |                  |          | City or Town, $111e$ |                  |   |
| mand 2 sho ealth and tem 27 is traumat   | 77 3   | 20a. Method of Disposition   | 5, 01 • / II.d.                     |                             |                             |                                |            | terv.               | Da         | ate              |          | Location - C         |                  |   |
| Baltimore,<br>permit. Pages 1 as<br>Department of He,<br>Important: If ite   | 17. Father's Name (First, Middle, Last)  John K. Trader  19a. Informant's Name/Relationship (Type, Print)  Larry C. Dennis, Jr./Husband  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rural Route Number, City or Town, State and State and Number or Rur |  |                                     |                             |                             |                                |            |                     |            |                  | •        | ,                    |                  |   |
| l <b>itir</b><br>nit. Pa<br>artmet<br>ortan  | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility   |  |                                     |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
| Ba<br>Perm<br>Depu<br>Imp<br>Inju  |  | Barranco & Sons, P.A. Severna Park Fune<br>495 Gov. Ritchie Hwy. Severna Park, MD                |                                     |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
| Physician  |  | 23a. Part I Enfor the discuss, or  |                                     | aused the death             | . Do not enter th           | e mode of                      | dying, su  | ch as cardi         | iac or res | piratory ar      |          |                      |                  | Approximate Interval Between Onset and        |
| ∖/Medical<br>≛xamin⊛r  |  | Immedite Cause (Final dise se a Cardiac arrhythmia   |                                     |                             |                             |                                |            |                     |            |                  |          |                      | Death            |   |
| _Administ  |  | or cal dition resulting in death)  Due to (or as a consequence of):  b. Congenital heart anomaly |                                     |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
|  | e  | Sequentially list conditions, if any, leading to immediate                                       |                                     | consequence o               |                             | ату                            |            |                     |            |                  |          |                      | _                | _   |
|  | mine   | cause. Enter Underlying Cause  | c                                   |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
| cuted<br>and<br>transit  | Exa  | events resulting in death) Last  | d.                                  | a consequence o             | π):                         |                                |            |                     |            |                  |          |                      | i,               |   |
| exe  | sician/Medical   | X UNPENDED   | 7                                   | · 1                         | 27 20                       | - L.C.E                        |            | MT                  | 200        |                  | /. / 1 / |                      |                  | ··· <del>- ··</del>                           |
| 8760, iificate be ong physicia   | Med  | IF FEMALE:   | 230. II yes,                        | ine a-b,                    | riaricy                     |                                |            |                     |            |                  | 23       | d. Date of de        | livery           |   |
| 687<br>ertific<br>iding 1  | ian/   | 23b. Was decedent pregnant in the past 12 months?  | Live                                | oirth<br>nant at time of de | 2 Fet                       |                                |            | Ectopic pre         | egnancy    |                  |          | Month                | Da               | ay Year                                       |
| Box 68<br>e death certif<br>the attending<br>ed for use as   | ysic   | 1 Yes 2 No 9 Unk   | nown 9 Unkno                        |                             | ath 5 Oth                   | er (Specify                    | )          |                     |            |                  | 1        |                      |                  |   |
| O. B.<br>at the de<br>1 by the<br>tached f   | , Phy  | Part II. Other significant conditi   | ons contributing to                 | o death but not re          | esulting in the u           | nderlying ca                   | use give   | n in Part I.        |            | 23e. Did t       | obacco   | use contribu         | te to th         | ne cause of death?                            |
| P.O.<br>ires that to<br>signed by<br>I be detact   | d by   |  |                                     |                             |                             |                                |            |                     | _          | 1 Ye             | s 2      | No 3                 | Proba            | ibly 4 Unknown                                |
| Records, The law require ficate has been si  | Completed  |  |                                     |                             |                             |                                |            |                     |            | 24a, Was<br>auto |          |                      |                  | opsy findings available impletion of cause of |
| ecc<br>he lav<br>ate ha  | performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 N  |  |                                     |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
| tal Rection: The certificate ector, page   | 25. Was case referred to medical 26.Place of Death (Check only one)  |  |                                     |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
| Vit<br>hysici<br>this c  | 10 E   | examiner?<br>1 ✓ Yes 2 No  |                                     | Inpatient 2                 |                             |                                | Oth        | ner <sub>4</sub> Nu | ursing Ho  | me 5             | Reside   | ence 6               | Other:           |   |
| ing Pl   |  |  |                                     |                             |                             |                                |            |                     |            |                  |          |                      |                  |   |
| SiOr<br>Attence<br>death<br>death<br>death<br>y the  | The state of Death State of Death State of State |  |                                     |                             |                             |                                |            |                     |            |                  |          | 10 1 1 0             |                  |   |
| Division of Vital pital or Attending Physician: our after death.  neral Director: After this certifiled in by the funeral director.  | ijij   | deter  | not be mined (Specify)              | e of injury - At no         | ome, rarm, street           | r, ractory, or                 | TICE DUILO | aing, etc.          |            | or Town,         | State)   | t, Millersvil        |                  |   |
| Hospit<br>4 hour<br>funers   |  | 29a. Certifier 1 Certifying Ph   | ysician: To the bes                 | at of my knowledge          | e. death occurr             | ed at the tin                  | ne. date   | and place           |            |                  | _        |                      |                  |   |
| Divisior To the Hospital or Attency within 24 hours after death To the Funeral Director:   | Medical  | (Circuit Gray  | niner:On the basis of               | of examination a            |                             |                                |            |                     |            |                  |          |                      |                  |   |
| To vit   | Me   | 29b. Signature and title of certifier  |                                     |                             |                             | 29c. L                         | icense n   | umber               |            |                  |          |                      |                  | h, Day, Year)                                 |
|  |  | Hancely bus  | thoulf, m                           | 1                           |                             |                                | D.C.M.i    | E.                  |            |                  | Ap       | oril 1               | 3, :             | 2010  |
|  |  | 30. Name and address of person   |                                     |                             |                             | MD 242                         | 01         | •                   |            |                  |          |                      |                  |   |
|  | Ata  | Assistant Medical E  |                                     | gistrar's Signatu           | re .                        |                                | .01        |                     |            | -                |          |                      |                  |   |
| Regis  |  | APP 1 6  |                                     | giottal o Oighata           | 1. bar                      | Kel                            |            |                     |            |                  |          |                      |                  |   |

State Registrar

ewa p.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCME

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Robert Lee Dunahugh April 1555 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Oct. 17, 1924 Months Hours Min. Maryland **Director** 219-12-1440 85 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 220 South Fork Dr. 21740 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 🔀 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: Completed 3 Widowed 4 Divorced White 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ada Griffith Edward Dunahugh mol. Page 1 and 2 shours of Health and Mr. ~ 27 is m. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 Vivian M. Dunahugh/Wife 220 South Fork Dr., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖁 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9 Department of Important: If any injury or Cedar Lawn Mem. Park 4/21/2010 Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. cardiac or respiratory arrest Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exam Hospital or Attending Physician; The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical Box 68760 the as IE FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, 1 🗌 Yes 2 No Completed 3 Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy death? certificate 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 2 No ည Inpatient ☐ ER/Outpatient 3 ☐ DOA this After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1, Natural 5 Pending Division death. 1 Yes within 24 hours after death

To the Funeral Director: / Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar Dul

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 12, 2010 Physician 1:55 A Katherine Evans /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte's Home, Inc. Washington Boonsboro If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 88 June 2, North Carolina 1921 Director 721-16-0459 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10f. Zip Code 212 Maple Avenue 21713 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🛣 No Specify. Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Madia once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Sul Pettus Yates Pauline Robbins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William R. Pumphrey, Jr./Son 4 Tudor Court Littlestown, Pennsylvania 17340 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Green Lawn Mem. Park: 04/16/2010 Williamsport, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 21. Signature of Euneral Service License 7606 Old National Pike Boonsboro, MD Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emented Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 No investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04-12-2010 2323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-5 1126 Opal Court Hagerstown, Maryland 21740 Muhammad K. Waseem, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature parte Registrar APR 13

ORIGINAL

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Da April 9, 2010 1658 hrs Medical Examine David Rockwell Exline 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 113 E High Street Sharpsburg Washington 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) **Funeral** Months Days Hours Director 06-27-1956 Manyland 53 1 X M 219-66-1758 2 F Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 X Yes 2 No s 23a or 28a-f show 28a-f show Washington Sharpsburg Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country USA 107 E. High St. 21782 ö uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married White, etc. 2XX No Yes 17 f Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 | XDivorced Specify: White ₫ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Electrical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Louis Exline Mary Leah Ebersole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Exline-Brother 119 W. Chapline St. Sharpsburg, Maryland 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Removal from State View Cemetery April 14,2010|Sharpsburg, Maryland Donation 5 Other 21. Signature of Furural Cashormer Faily Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Part I. Entel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause on each line (Mindle at Death a. Chronic Alcohol Abuse Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the detached i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>о</u> has been signed by 2 should be detached δ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed Records. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 1 🗸 Yes certificate Yes 2 No 2 No Hospital r Attending Physician: 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 this 1 V Yes 2 No After 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural Pending 1 Yes 2 No hours a er cleath the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined thin 24 hours a (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 10, 2010 30. Name and address of person who completed cause of death (Item 23a) 5H-5 Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Mona, Dr. Yerr) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 1/2001 **OCME 2006** 

**OCME** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Janice Louise FURLEY Month 6:06 AM Pri 2010 Medical 4a. Facility Name (if not institution, give street and number) c. County of Death
Washington 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown . Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Hours 217-44-7669 March 13, 1947 63 Maryland Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director or 28a-f Big Pool Maryland Washington 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21711 11572 Big Pool Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white "natural", 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meagnose. Elementary/Seconday (0-12) College (1-4 or 5+) manufacturing machine operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Long James L. Gaynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1223 Torytown Road, Bunker Hill, WV 25413 Shannon Spears - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/15/10 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Broadfording Mem.Gardens MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 / the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ be detached for in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? After this certificate Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D62440 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JH-10

DHMH 17 Rev 7/2009

State Registrar egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** James A. Fortner, Jr. 2:40 P 2010 April 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Harwood Mandrin Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 💢 M 2 🗆 F 427-70-0377 Yrs Oct. 03,1938 Mississippi Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mcdical Evanting Imust be notified at once. Anne Arundel Pasadena 1 ☐ Yes 2 X No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 210 Drum Avenue S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Force: 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 2 XNo 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President-Technical Services Northrop Grumman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Eleise Sellier James A. Fortner, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, MD 21122 210 Drum Avenue S. Marian Sue Fortner / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 06, 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Baltimore, MD 2010 Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) Barrancoddess පුර්රාප්, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Signature of Funeral Service Licenses 283. Fan 1. Enter the disease, or dom shock, or heart failure. List only reations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. avcoma Immediate Cause (Final 11 MOS. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/Medical ģ Completed Be Medical Certification: To

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O.

Division of Vital Records,

1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 4 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Day

Year

Month

23e. Did tobacco use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

gate Rd. Annapolis, Ud. 21401

31. Date filed (Month, Day, Year) APR 0 6 2010

29b. Signature and title of certifier

32. Registrar's Signature

loud llo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

4 ☐ Pregnant at time of death

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4/1/2010 Physician/ Charles Henry Griffiths 2am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7101 Bayfront Dr. Anne Arundel Apt. 111 Annapolis If Under 1 Year If Under 24 Hrs. Social Security Number Sex 1444M 2 🗆 F 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours *491*15/1922 487-26-8559 88 Director PA Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 🛠 🔽 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7101 Bayfront Dr. Apt. 111 21403 USA items within 72 hours after death 12. Was Decedent Ever in U.S.
Amed Forces?
124 Yes 2 No 1942If Yes, Give 1980 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or 1 Never Married 243 Married ۾ Maryland 21215-0036 White 1 Yes 2 No Specify: 1980 3 - Widowed 4 - Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Officer US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Henry Griffiths Hazel Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Griffiths Wife 7101 Bayfront Dr. Apt. 111 Annapolis. MD 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2xx Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/3/2010 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 2140 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lanocarcinona disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 2 No 1 ∐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number ec. 026373 Apr. 1 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Greenfield

Registrar

DHMH 17 Rev 7/2009

del

31. Date filed (Month, Day, Year)

Salonas

APR 0 5 2010

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |   | For State  |                         | St          | ate of                 | Marylar   | nd / Depa                           |                           |  |   | and N            | /lental H                              | lygien                                | e 21              | 110                         | 125                                 | 567         |
|--|---|--|-------------------------|-------------|------------------------|---|-------------------------------------|---------------------------|--|---|------------------|--|---------------------------------------|-------------------|-----------------------------|-------------------------------------|-------------|
|  | Registrar  1. Decedent's Name (First, Middle, Last) |  |                         |             |                        |   | tificate of Death                   |                           |  |   | 2. Date of       | Reg. No.                               |                                       |                   |                             |                                     |             |
| Physicia   |   | Walter Allen Hunt  |                         |             |                        |   |                                     |                           |  |   |                  | Month<br>Apini                         |                                       | Day (             | Year<br>ZOIC                | 3. Time of 1742                     |             |
| Medic<br>Examin  |   |  |                         |             |                        |   |                                     | 4b. City,                 | 4b. City, Town, or Location of Death   |   |                  |  | 4c. County of Death                   |                   |                             |                                     |             |
| /  |   | 104 East Chestnut Street   |                         |             |                        |   | Delmar                              |                           |  |   |                  | Wicomico                               |                                       |                   |                             |                                     |             |
| Funeral  |   | 5. Social Security Nur   |                         | 6. Sex      |                        |   | last birthday)                      | If Under                  | r 1 Year<br>Days   | If Under<br>Hours                           | 24 Hrs.<br>Min.  | 8. Date of                             |                                       | -)                | 9. Birth                    | olace (State or                     | Foreign     |
| Director   |   | 212-66-  |                         | 1 🖾 M       | 2 LJ F                 | 5.  | 5 Yrs.                              | IVIOITIIS                 | Days   | Hours                                       | IVIII I.         | Dec. 1                                 | 4, 19                                 | 54_               | Mai                         | yland                               |             |
| d d  | _   | Usual Residence of D   | Decedent<br>10b. County |             |                        | 10c Ci  | ty, Town or Lo                      | cation                    |  |   |                  |  |                                       |                   |                             | l 0d. Inside Cit                    | v Limite    |
| a-f sh   | cto   | MD   | ,                       | omico       |                        |   | Delmar                              | Sation                    |  |   |                  |  |                                       |                   |                             | 1 🖾 Yes                             |             |
| or 28g   | <b>Funeral Director</b>                             | 10e. Street and Numl   |                         |             |                        |   | DOLINGI                             | 10f. Zip                  | Code   | -   |                  |  | 100 (                                 | Citizon of        | What Cou                    |                                     |             |
| th with the Maryland<br>ms 23a or 28a-f show<br>must be notified at  |   | 104 East Chestnut Street   |                         |             |                        |   |                                     | 21875                     |  |   |                  |  |                                       | U.S.              |                             | iti y i                             |             |
| ems  | nne   | 104 Eas  | St Glies                |             |                        | ent Ever in U.                                  | .S. 13. V                           | Vas Deced                 |  |   | gin? (Spe        | ecify Yes or N                         |                                       |                   | ce - Americ                 | an Indian.                          |             |
| er de<br>or it   | by F  | 1 Never Marrie   | ed 2 🗆 Marri            |             | rmed Force             |   | l'                                  | Yes, spec                 | cify Cuban   | n, Mexican                                  | , Puerto         | Rican, etc.)                           |                                       |                   | ick, White,                 | etc.                                |             |
| rs aft<br>Iral",<br>Exa  |   | 3 Widowed 4 X Divorced If Yes, Give Year or Dates.   |                         |             |                        |   |                                     | Yes 2 K No Specify:       |  |   |                  | Specif                                 | y: V                                  | vhite             |                             |                                     |             |
| hou "natu  | Completed   | (Spec  | 15. Deceden             |             |                        |   | 16a. Deced                          | lent's Usua<br>kind of wo | al Occupa  | ition                                       | t of work        | ino                                    | 16b.                                  | Kind of E         | Business In                 | dustry                              |             |
| hin 72<br>he.<br>han e Me  |   | Elementary/Secon   |                         |             | ollege (1-4            | or 5+)  | life. Di                            | O NOT use                 | e retired)   |   | cor work         | 9                                      |                                       |                   |                             |                                     |             |
| d with lygier ther t   | Be C  | 12   |                         |             |                        |   |                                     | Sale                      | sman   |   |                  |  |                                       |                   | <u>urnit</u>                | ure                                 |             |
| ntal File  | 면<br>의  | 17. Father's Name (Fi  |                         | ,           |                        |   |                                     |                           |  |   |                  | e (First, Midd                         |                                       |                   |                             |                                     |             |
| d Mel<br>d Mel<br>mark<br>matic  |   | Clyde A. Hunt  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addres   |                         |             |                        |   |                                     |                           | Janice Evelyn Sullivan ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) |   |                  |  |                                       |                   |                             |                                     |             |
| 2 sho<br>th an<br>27 is<br>traun   |   | Robert   |                         |             | (Nepi                  | hew)  |                                     | ig Address<br>Wood        |  |   |                  |  | Seaf                                  |                   |                             | 19973                               |             |
| and<br>Heal<br>tem   |   | 20a. Method of Dispo   |                         | 501         | (пер.                  | 20b.  | Place of Dispo                      | sition (Nan               | ne of  | - 1   | _                | Date                                   |                                       |                   | - City or To                |                                     |             |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.                        |   | 1 Burial 2   |                         |             | val from St            | tate  | cemetery, cren                      | natory or o               | ther place   |   |                  |  |                                       |                   | ,                           |                                     |             |
| mit. Partmoortal   |   | 4 Donation 5 Other (Specify) Crematory of DelmarvaApril 6, 2010 Delmar, Delaware  21. Standardure of Funeral Service Licensee 22. Name and Address of Facility |                         |             |                        |   |                                     |                           |  |   |                  |  |                                       |                   |                             |                                     |             |
| Depar<br>Impo<br>any ir  |   | Cons   | Then:                   | to          | 0.11.0                 | 11.   | Ş                                   | hort<br>3 Eas             | Fune   | ral l                                       | Home<br>Stre     | et D                                   | elma                                  | r. D              | E 19                        | 940                                 |             |
|  |   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate    |                         |             |                        |   |                                     |                           |  |   |                  |  |                                       |                   |                             |                                     |             |
| Physician/   |   | Immediate Course /Final  |                         |             |                        |   |                                     |                           |  |   |                  |  |                                       |                   |                             | Interval Between<br>Onset and Death |             |
| Medical  |   | disease or condition resulting in death)  a. Due to (or as a consequence of):  |                         |             |                        |   |                                     |                           |  |   |                  |  |                                       |                   |                             |                                     |             |
| Examiner   | _   | Sequentially list conditions, b. End stage reneal clidecree  |                         |             |                        |   |                                     |                           |  |   |                  |  | 2                                     |                   |                             |                                     |             |
| 7. ≒   | dical Examiner                                      | if any, leading to immediate  Cause. Enter Underlying  Due to (or as a consequence of):  |                         |             |                        |   |                                     |                           |  |   |                  |  |                                       |                   |                             |                                     |             |
| ate be executed<br>physician and<br>the burial-transit   | xan   | Cause (Disease or iinjury that initiated events c  |                         |             |                        |   |                                     |                           |  |   |                  | -                                      |                                       |                   |                             |                                     |             |
| e execian di   | alE   | resulting in death) La   | 451                     |             | Due to (or             | as a conseq                                     | derice oi).                         |                           |  |   |                  |  |                                       |                   |                             |                                     |             |
| physi  |   |  |                         | d           |                        |   |                                     |                           |  |   |                  |  |                                       |                   |                             |                                     | -           |
| ath certifica<br>attending p   | Ž   | IF FEMALE:   | reanant                 | 23c. lf     | yes, outco             | me of pregna                                    | ancy                                |                           |  |   |                  |  |                                       | 334 D             | ate of deliv                | en/                                 |             |
| atter<br>for u   | cial  | in the past 12 months?   |                         |             |                        |   |                                     |                           |  |   |                  |  | · · · · · · · · · · · · · · · · · · · |                   |                             | ear                                 |             |
| requires that the de<br>been signed by the<br>should be detached   | by Physician/Me                                     | 1   Yes 2   No 9   Unknown   9   Unknown   |                         |             |                        |   |                                     |                           |  |   |                  |  |                                       |                   |                             |                                     |             |
| that the ned be deta   | y P   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause  |                         |             |                        |   |                                     |                           | cause give   | given in Part I. 23e. Did tobacco use contr |                  |  |                                       | tribute to tl     | bute to the cause of death? |                                     |             |
| uires<br>in sign   | edk   |  |                         |             |                        |   |                                     |                           |  | 1 \[ \text{Yes}  2 \]                       |                  |  |                                       | 2 <b>&amp;</b> No | No 3 ☐ Probably 4 ☐ Unknown |                                     |             |
| w req  | plet  |  |                         |             |                        |   |                                     |                           |  |   |                  | 24a. W                                 |                                       | 24b.              | Were auto                   | psy findings at                     | vailable    |
| The lar  | Completed   |  |                         |             |                        |   |                                     |                           |  |   |                  |  | itopsy<br>erformed?<br>es_2           | No                | death?                      |                                     | iuse of     |
| rtifica  | Be C  | 25. Was case referred examiner?  | to medical              |             |                        |   |                                     |                           | 26. Pla  | ce of Dear                                  | th <i>(Ch</i> ec | k only one)                            | 3 2 2                                 | NOT               | 1 100                       | 2 3 110                             |             |
| nysici<br>nis ce<br>direc  | To  | 1 Yes 2  | No                      | Hospit      | al:<br>1 🗌 In          | patient 2                                       | ER/Outpatier                        | t 3 DOA Other: 4 Nursing  |  |   |                  | Home 5 🕅 Residence 6 🗌 Other (Specify) |                                       |                   |                             |                                     |             |
| ng Pł<br>fter tł<br>ineral   |   | <ol> <li>Manner of Death</li> <li>Natural</li> </ol>   | 5 Pending               |             | Ba. Date of<br>(Month, | injury<br>Day, Year)                            | 28b. Time of<br>injury              |                           |  |   |                  | 28d. Describe how injury occurred      |                                       |                   |                             |                                     |             |
| tendilleath.   | ific  | 2 Accident 3 Suicide   | Investig                | ation       |                        |   |                                     | М                         |  | Yes 2 🗆                                     | No               |  |                                       |                   |                             |                                     |             |
| or Attendia<br>after death.<br>Director: A<br>in by the fu   | Certificate:  | 4 Homicide   | determi                 |             |                        | Injury - At h<br>, etc. <i>(Sp</i> ec <i>if</i> | ome, farm, stre<br>y)               | eet, factory              | , office   |   |                  |  | n <i>(Str</i> eet a<br>Town, Stai     |                   | per or Rura                 | Route Number                        | er,         |
| pital ours a eral C  |   |  |                         |             |                        |   |                                     |                           |  |   | nor on otate     |  |                                       |                   |                             |                                     |             |
| the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and impleted filled in by the funeral director, page 2 should be detached for use as the burial-transi | Medical   |  | Medical Ex              | caminer: Or | n the basis            | of examination                                  | on and/or invest<br>by knowledge, c | igation, in               | my opinior   | n, death oc                                 | ccurred a        | t the time, da                         | te and plac                           | ce, and di        | ue to the ca                | use(s) and mar                      | ner stated. |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2  | Σ   | 29b. Signature and   | 11.0                    | ruise FIBC  | Moner: 10              | ine best of II                                  | is anomieuge, t                     |                           | License  |   | ana piat         | o, and due to                          |                                       | -                 | ed (Month,                  |                                     |             |
|  |   |  |                         |             |                        |   |                                     | H50497                    |  |   |                  |  | 4/5-110                               |                   |                             |                                     |             |
| 201  |   | 30. Name and addres  | ss of person w          | ho complet  | ted cause              | of death (Iter                                  | n 23a) (Type, P                     | rint)                     |  |   |                  | <u> </u>                               | ,                                     | '                 |                             | . 42 - 1                            |             |
| U  |   | Chri   |                         | de          |                        |   | 100 €                               | Corn                      | 11 3   | 7.  |                  | Sal                                    | buy.                                  | 1                 | m 5                         | 1801                                |             |
| State<br>Registra  |   | 31. Date filed (Month,   | Day, Year)              | 2010        | 32. Feg                | istrar's Signa                                  | 100 E                               | are                       | /  |   |                  |  |                                       |                   |                             |                                     |             |

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 03 Month 2 Date of Death **Physician** 31 MARGARET ELIZABETH HUGHES 2010 5:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL MANOR TALBOT EASTON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 1 M 2 XF Director 151-01-7318 96 11/18/1913 **NEW JERSEY** Usual Residence of Decedent 10a, State 10b. County show 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 No MD TALBOT EASTON 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 501 DUTCHMANS LANE 21601 Funeral UNITED STATES Нет в 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō If Yes, Give Year or Dates: 1 ☐ Yes 2 🔣 No Specify þ Specify: WHITE 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES ASSOCIATE RETAIL 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER CHAMBERS 0 MARGARET OLSEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Health a 7851 FOLLYS COVE RD., ST. MICHAELS, MD HOWARD C. HUGHES/SON permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
CHESAPEAKE CREMATION 4/2/2010
CENTER 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 200 S. HARRISON ST., EASTON, FUNERAL F MD 21601 HOME, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Skeans disease or condition resulting in death) /Medical Due to (or as a sonsequence of) Examiner mo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the, asi attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.O. ed by the detached 1 ☐ Yes 2 ☐ No 9 Unknown signed I significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Physician: The certificate Division of Vital 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending death, 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) b WILLIAM H. WOOD, MD 501 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year, Registrar's Signatur State APR 0 2 2010 Registrar

| 10-02645  |                     | Please Type or Print in Black Indelik  |   |   | ble.   | 10560  |  |  |  |  |  |
|---|---------------------|--|---|---|--|--|--|--|--|--|--|
| Robert Glenn H  |                     | Otate of Maryland / Departine  | nt of Health and Mental Hy<br><i>te of Death</i>  | /giene<br>Reg.  |  | 12569  |  |  |  |  |  |
| Physic<br>Medical Exam  | an/                 | 1. Decedent's Name (First, Middle, Last) Robert Glenn Holman, Jr.  |   | 2. Date of Death  | av Year  | 3. Time of Death<br>2010 hrs                 |  |  |  |  |  |
|   | 94                  | 4a. Facility Name (if not institution, give street and number) 212 Dale Road   | 4b. City, Town, or Location of Death<br>Pasadena  |   | 4c. County of Death Anne Arundel                           |  |  |  |  |  |  |
| Funeral<br>Director   |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe   | day) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.  Yrs.  | 8. Date of Birth (Dec. 20   | 1061 Cou   | hplace (State or Foreign<br>intry)<br>ryland |  |  |  |  |  |
| and<br>f show any<br>pnce.  | or                  | Usual Residence of Decedent  10a. State 10b. County Maryland Anne Arundel 10c. City, Town or Location Pasadena   |   |   |  |  |  |  |  |  |  |
| the Maryl   | by Funeral Director | 10e. Street and Number<br>212 Dale Road  | 10f. Zip Code 21122   | 10g.  | 0g. Citizen of What Country? $U_{ullet}S_{ullet}A_{ullet}$ |  |  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland beatment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.  |                     | 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced or Dates:  | <ul> <li>13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto</li> <li>1 Yes 2 X No specify:</li> </ul> |   | 14. Race - Americ<br>White, etc.                           | an Indian, Black,<br>hite                    |  |  |  |  |  |
| 1036<br>vithin 72 hours<br>ene.<br>er than "natur<br>Medical Exami  | Completed t         | Elementary/Secondary (0-12) College (1-4 or 5+)  | ecedent's Usual Occupation (Give kind of w<br>uring most of working life. DO NOT use retin<br>Mail Clerk                          | ed)   | State of Maryland  |  |  |  |  |  |  |
| 215-0<br>be filed w<br>ntal Hygi<br>rked othe   | Be Co               | 17. Father's Name (First, Middle, Last) Robert Glenn Holman, Sr.   | 18.Mother's Name<br>Caro  | (First, Middle, Mai<br>1 Lee Lai  |  |  |  |  |  |  |  |
| MD 21<br>12 should<br>th and Me<br>27 is ma   | To                  |  |   | Route Number, City or Town, State, Zip Code)  a, Maryland 21122   |  |  |  |  |  |  |  |
| timore, I<br>t. Pages I and<br>treent of Healt<br>reant: If item  |                     | 20a. Method of Disposition  1 State    Cremation   3   Removal from State   20b. Place of Disposition (Name of cemetery, crematory or other place)   4   Donation   5   Other Specify:   Annapolis, Maryland   Annapolis, Ma |   |   |  |  |  |  |  |  |  |
|   | 8 8                 | 21. Signatory of Fundral Dervice Ligensee  22. Name and Address of Facility John M. Taylor Funeral Home  147 Duke of Gloucester St., Annapolis, MD 214  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Inte   |   |   |  |  |  |  |  |  |  |
| Physician<br>Examiner   |                     | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):   |   |   |  |  |  |  |  |  |  |
|   | ner                 | Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause  b   |   |   |  |  |  |  |  |  |  |
| cecuted<br>and<br>transit   | Examiner            | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  |   |   |  |  |  |  |  |  |  |
| O,<br>e be execu<br>sician and  | edical              | UNPENDED AMENDED   |   |   |  |  |  |  |  |  |  |
| Box 68760, e death certificate be execut the attending physician and of for use as the burial - tran  | sicial              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown   | Fetal death 3 Ectopic pregnal Other (Specify)   | 23d. Date of delivery<br>Month D  | ay Year  |  |  |  |  |  |  |
| b, P.O. Be ires that the dear signed by the a   | by Phy              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  |   |   |  |  |  |  |  |  |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | completed           | 24a. Was an autopsy findings available performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No   |   |   |  |  |  |  |  |  |  |
| ital Fisition:  | Be C                | 25. Was case referred to medical examiner?  1 Vee 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 VOther: Scene  |   |   |  |  |  |  |  |  |  |
| n of V<br>ding Phy:<br>After thi<br>funeral d   | on: To              | 27. Manner of Death  28a. Date of Injury  28b. Ti  CMpgtb, Day, Year)  COLIN   | me of Injury 28c. Injury at Work?   | 28d. Describe how injury occurred   |  |  |  |  |  |  |  |
| Division of N To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After to ompletely filled in by the funeral to   | Certification:      | 2 Accident Investigation Investigation Apr 4, 2010 1954 3 V Suicide 6 Could not be determined (Specify) Single Family Ho   |   | 8f. Location (Street and Number or Rural Route Number, City<br>or Town, State)<br>2 Dale Road, Pasadena, MD |  |  |  |  |  |  |  |
| Di<br>Fo the Hospital<br>within 24 hours a<br>Fo the Funeral  | Medical C           |  |   |   |  |  |  |  |  |  |  |
| To Will   | Me                  | and manner stated.  29b Signature and title of certifier   | 29c. License number   | 2   | 9d. Date signed (Mon                                       | th, Day, Year)                               |  |  |  |  |  |

12W

Registrar

31. Date filed (Month, Day, Year)

Laron Locke MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 \restriction State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 20T0 1:15 PM April Jens R. Jacobsen, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Bradford Oaks Clinton 9. Birthplace (State or Foreign New York 6. Sex 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days July 22, Year 1930 Hours 1 XM 2 □ F 79 **Director** 128-22-6604 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 other traumatic event, the Madizal English or other traumatic event, the Madizal English of the process. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🗓 No Upper Marlboro Prince Georges Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A 20772 12437 Persimmon Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married 1 🗌 Yes 2 💢 No 3XXWidowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) School School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Caroline Lacher Jens Jacobsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27048 Bosse Dr. Mechanicsville, MD 20659 Jens Jacobsen, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 4/16/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licenses M01555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? is certificate has been signed I director, page 2 should be det 3 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie

15+1

State Registrar (Check

29b. Signatu

3 and title of certifie

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

LINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:20 P M GENEVIEVE E. 04 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CAROLINE HOME FOR HOSPICE DENTON CAROLINE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 0172071917 NEW YORK Director 93 071-14-8106 Usual Residence of Decedent or 28a-f show notified at shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director BINGHAMTON BROOME 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 13905 UNITED STATES 35 ORTON AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ VINCENT CEPONIS ELEANOR TWARYONAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace once, JON C. LEWIS/GRANDSON 23860 MT. PLEASANT RD., ST. MICHAELS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) SPRING HILL CEMETERY 04/10/2010 EASTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & 200 S. HARRISON ST. HOME, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition months Medical resulting in death) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month detached g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? this certificate 1 Yes 2 No Yes ours after death.

eral Director: After this certific filled in by the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 1-Spic ? Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

enevieve

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month. Dav. Year)

601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last)
Sallie V. Klo 2. Date of Death Klotz April Physician/ 2010 10:25 AM Medical 4c. County of Death
Prince George's 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clinton 6911 Crafton Lane 9. Birthplace (State or Egreign Year) 1910 Upper Marlboro, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day Ye Days Hours Min 1 M 2 XX 100 577-28-9496 Director Usual Residence of Decedent f show 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director Clinton 1 Yes 2XXNo Prince George's Maryland 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 20735 USA 6911 Crafton Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: 3 🙀 Widowed 4 🗌 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pharmaceutical Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Distributor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carr D. Pearle ၉ Vance James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12107 Brandywine Rd, Brandywine, MD 20613 Carolyn Spargo - Daughter 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 XXCremation 3 Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc. Signature of Funeral Service Licenses M01533 47 6633 Old Alexandria Ferry Rd., Clinton,MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23h. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions þ 2 No 3 Probably 4 Duknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **II** No 1 🗌 Yes 26. Place of Death (Check only one) Division of Vital æ 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 R No 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat

State Registrar

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celtimore Ave, Ste, A.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Virginia April 2010 8:45 P M Pearl Kaetzel 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Williamsport Nursing Home Williamsport Washington 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Days Months Hours 1 □ M 2 🔏 F 214-74-6607 100 May 26, 1909 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 1 □Yes 2 X No Maryland Washington Clear Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13134 Independence Road 21722 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edgar Line 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Kaetzel - Son 13134 Independence Rd. Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition \*\*Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Broadfording CemeteryApril 13, 2010 Hagerstown, Maryland ure of Huneral Service Lo Osborne drumeraly Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PARKINSON DISEASE END- STAGE YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Nadical Examiner must be notified at

s 1 and 2 should be filed wi f Health and Mental Hygier ftem 27 is marked other th other traumatic event, the

t: If item 2,

Department of Important: If it any injury or conce.

illed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Vital Records,

Division of

Pages 1

burial physician the attending p for use as as à signed by peen cate has by page 2 s certificate director.

Examiner Physician/Medical ģ Completed Be Certification: To

be executed The law requires that the death certificate To the Hospital or Attending Physician: this After thi funeral of n 24 hours aller ucc. he Funeral Director: Af npletely within 2.

JH-1

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 12, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. ARTIZAN 21795 ST WILLIAMSPORT MO

31. Date filed (Month,

IED HOWE,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ MARCH 26. HARRY MAURICE KRAMPF, JR. 2357 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 7230 BOB'S WAY EASTON TALBOT Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F MAY 19, 1928 095-24-0485 Director NEW YORK Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT 1X Yes 2 No EASTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 7230 BOB'S WAY 21601 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. WHITE If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BUSINESS ENTREPRENEUR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY M. KRAMPF, SR. ANITA MCAULIFFE and 2 should be Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7230 BOB'S WAY, EASTON, MD 21601 7230 BOB'S WAY, EASTON, MD MARTHA WHELAN KRAMPF, WIFE or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)

ST. JOSEPH'S CEMETERY 3/31/2010 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CORDOVA, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. JOHN MERCERO R 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MYOCAIdIAL Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnan-23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 1 🗆 Yes 2 🗆 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at 1. Natural 5 Pending (Month, Day, Year) Division 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one)

JORGE H. ABREGO

29b. Signature and title of certifier

598 CYNWOOD DRIVE, STE. 104, EASTON, MD 32. Registrar's Signature

MO

31. Date filed (Month, Day, Year) MAR 3 0 2010

a/ho

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 29c. License number

0995/132

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Ne'vaeh, Miracle, Lewis 5: 20 Pm 2010 01 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore University of Maryland Meet cat Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthda If Under 1 Year | If Und If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12–26–2009 Birthplace (State or Foreign Country) Months 3 Days Hours 1□ M 2X F 214-87-2016 MDUsual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1√Yes 2□No Wicomico Hebron: 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21830 USA 107 Chapel Branch Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Talonda R. Brown Gary C. Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Chapel Branch Dr, Hebron, MD 21830 Talonda R. Brown/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Cem 4-8-2010 21. Signature of uneral Service Licensee 22. Name and Address of Facility 17 W. Isabella St. Pennie Smith 917 W. Isabella St. Funeral Home Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vespiratory 1 month Due to (or as a consequence of): biondo pulmonay displasice amontus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): trisomy 13 Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 ☑ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

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Director

Funeral

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Completed

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**Funeral** 

**Director** 

d other than "natural", or items 23a or 28a-f show event, the Medical Evantian must be notified at

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n. any injury or other traumatic event, It. Mente once.

Baltimore, Maryland 21215-0036

Box 68760

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Records,

of Vital

Division

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical ≥ Completed Be

Certification: To

Medical

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier Kise Mani

6 Could not be determined

29c. License number

MD 21201

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Greene st, suite # 110 Baltimore.

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 07 2010

the

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|                   | State Registrar  |   |   | Cer                          | tificate o   | f Death                                 |   | Reg. No           | . ZUIL                              | 1 (2) (                             |
|-------------------|--|---|---|------------------------------|--|---|---|-------------------|-------------------------------------|-------------------------------------|
| n/                | 1. Decedent's Name (First, Middle,   | ŕ   |   |                              |  |   | 2. Date of D<br>Month                   |                   |                                     | 3. Time of Death                    |
| al                | Estelle Louise   |   |   |                              |  |   | <u>April</u>                            |                   | 2010                                | 7:58 p <sup>M</sup>                 |
| er                | 4a. Facility Name (if not institution, g<br>Vantage House  | give street <b>a</b> nd numb                  | er)   |                              |  | , or Location of De<br><b>umbi</b> a    | eath                                    | 40                | County of Deat                      |                                     |
|                   |  | 6. Sex 7                                      | . Age (In yrs. I                                  | ast birthday)                | If Under 1 Ye  | ar If Under 24 F                        |   |                   | Howard<br>9. Birt                   | thplace (State or Foreign           |
|                   | 215-36-5657  | s Hours M                                     | 03/26   | <u>/1910</u>                 | 0 Was  | hington, DC                             |   |                   |                                     |                                     |
| 5                 | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. Cit  | y, Town or Lo                | cation   |   | <u>-</u> -                              |                   |                                     | 10d. Inside City Limits             |
| Director          | MD Howar   | rd.   |   | olumbi                       | .a   |   |   |                   |                                     |                                     |
|                   | 10e. Street and Number   |   |   |                              | 10f. Zip Cod   | 9                                       | 10g. Ci                                 | itizen of What Co | untry?                              |                                     |
| runerai           | 5400 Vantage Po  | oint Road                                     | SNF #3  | 306                          | 2  | 1044                                    |   | Unit              | ted Stat                            | es                                  |
|                   | 11. Marital Status  1  Never Married 2  Marrie   | 12. Was Deced                                 | es?   |                              | Vas Decedent of<br>Yes, specify Co   | f Hispanic Origin?<br>Jban, Mexican, Pu | (Specify Yes or No<br>erto Rican, etc.) | -                 | 14. Race - Amer<br>Black, White     |                                     |
| ğ<br>Q            | 3   Widowed 4 □ Divorced   | ed 1 ☐ Yes<br>If Yes, Give<br>Year or Date    |   | 1 1                          | 1 ☐ Yes 2 ☒No Specify:   |   |   |                   |                                     | hite                                |
| olete             | 15. Decedent'<br>(Specify only highest   | 's Education                                  |   |                              | lent's Usual Occ   |   |   | 16b. K            | (ind of Business                    | Industry                            |
| Completed by      | Elementary/Seconday (0-12)   | College (1-4                                  | or 5+)  | life. D                      | O NOT use retire   | e during most of wed)                   | vorking                                 |                   | O **                                |                                     |
| BeC               | 17. Father's Name (First, Middle, La.  | et)   |   | l Ho                         | memaker  | 40. Mada ada 4                          | Name (First, Middle                     | . 44-1-4          | Own Hom                             | e                                   |
| ٥                 | Andrew Roswell   | •   |   |                              |  |   | Estelle                                 | -                 | ,                                   | •                                   |
|                   | 19a. Informant's Name/Relationship   |   |   | 19b. Mailir                  | ng Address (Stre   |   | Rural Route Numb                        |                   |                                     |                                     |
|                   | John Norman Lau  | er - son                                      |   | 1341                         | 5 Shake  | r Blvd.                                 | 10G4 Clev                               | <i>r</i> elan     | d. Ohio                             | 44120                               |
|                   | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3  | B ☐ Removal from S                            |   | Place of Dispo               | sition (Name of<br>natory or other p   |   | Date                                    | 1                 | ocation - City or                   |                                     |
|                   | 4 Donation 5 Other (Sp   | ecify)  | Arl   |                              | Nation   |   | /17/2010                                | Ar                | lington                             | , VA                                |
|                   | 21. Signature of Funeral Service Lic   | ensee   | 01044   | 22                           | Name and Add   | Iress of Facility                       | Harry H.                                | Witz              | ke's Far                            | mily F.H.Ind                        |
|                   | 23a. Part 1. Enter the disease, or co  | omplications that ca                          | used the deat                                     |                              |  |   |   |                   | et City                             | , MD 21043<br>Approximate           |
|                   | shock, or heart failure. List on<br>Immediate Cause (Final   |   |   |                              |  |   |   |                   |                                     | Interval Between<br>Onset and Death |
| 10                | disease or condition resulting in death)   |   | <u>betes   1</u><br>r as a consequ                |                              | 15   |   |   |                   |                                     |                                     |
| _                 | Sequentially list conditions, b. Hypertension  |   |   |                              |  |   |   |                   |                                     |                                     |
| =xamine           | If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury Anemia |   |   |                              |  |   |   |                   |                                     |                                     |
|                   | that initiated events resulting in death) Last  C. Due to (or as a consequence of):                                    |   |   |                              |  |   |   |                   |                                     |                                     |
| Physician/Medical |  | d   |   |                              |  |   |   |                   |                                     |                                     |
| Me                | IF FEMALE:   |   |   |                              |  |   |   |                   |                                     |                                     |
| ian/              | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outco                            | ome of pregna<br>irth 2  Feta<br>ant at time of a | al death 3 🗌                 | Ectopic pregnation of the control of | ancy                                    |   |                   | 23d. Date of del<br>Month           | ivery<br>Day Year                   |
| يرزر              | 1 ☐ Yes 2 XNo<br>9 ☐ Unknown   | 9 Unkno                                       |   | Jeatii 5∟                    | otner (specify)  |   |   |                   |                                     | ,                                   |
|                   | Part II. Other significant condition   | s contributing to dea                         | ath but not res                                   | ulting in the u              | nderlying cause  | given in Part I.                        | 23e. Did                                | tobacco u         | use contribute to                   | the cause of death?                 |
| ed                | Dementia   |   |   |                              |  |   | _ 1 🗆                                   | Yes 2             | <b>X</b> No 3 □ Pr                  | robably 4 🗆 Unknown                 |
| Completed by      |  |   |   |                              |  |   | 24a. Was                                |                   | 24b. Were aut                       | topsy findings available            |
| Con               |  |   |   |                              |  |   | _ perf                                  | ormed?            | death?                              | 2 🗓 No                              |
| Be                | 25. Was case referred to medical examiner?   | Hospital:                                     |   |                              |  | Place of Death (Cathori                 | heck only one)                          |                   |                                     |                                     |
| 0                 | 1 Yes 2 No 27. Manner of Death   | 1 ☐ Ir  | patient 2  injury                                 | ER/Outpatier<br>28b. Time of | t 3 DOA 28c. In  |   | g Home 5 K Res                          |                   |                                     | ify)                                |
| cate              | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident Investiga  | (Month  | , Day, Year)                                      | injury                       | W  | ork?                                    | 28d. Describe                           | now injur         | y occurred                          |                                     |
| Certificate:      | 3 Suicide 6 Could no<br>4 Homicide determin  | ot be 28e. Place o                            |   |                              | et, factory, offic   | e                                       |   |                   |                                     | rai Route Number,                   |
|                   |  |   | , etc. (Specify                                   |                              |  | <u>.</u>                                | City or To                              |                   |                                     |                                     |
| Medical           | (Check 2 \(\sumeq\) Medical Exa  | Physician: To the bes<br>aminer: On the basis | of examination                                    | n and/or invest              | igation, in my op  | inion, death occurre                    | ed at the time, date                    | and place         | e, and due to the o                 | cause(s) and manner stated          |
| ž                 | only one) 3 L Certifying N 29b. Signature and title of certifier   | lurse Practioner: To                          | the best of m                                     | y knowledge, o               | leath occurred at  | the time, date and                      | place, and due to t                     | he cause(s        | s) and manner as the signed (Month) | stated.                             |
|                   | Marine A   |   | 2   | 10                           |  | 55425                                   |   | 4 16              | a / 1 ~                             | i, Day, rear)                       |
|                   | 1 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |   | 1/10  | CY                           |  | JJ42J                                   |   | 1.19              | 1110                                |                                     |
|                   | 30. Name and address of person wh  | no completed cause                            | of death (Item                                    | 23a) (Type, P                | rint)  |   |   | 1/                | l                                   | -                                   |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April <sup>Day</sup> 2010 Physician/ Hazel ٧. Mynes 7:20 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours (Month Day 09 27 227-09-5453 Virginia Director 98 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Salisbury Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 900 Booth St. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 2 1 Never Married 2 Married 2 X No 1 Yes 2 No Specify: If Yes, Give Specify: white 3 Midowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) assembly line worker Westinghouse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Tabitha Sue Wright John Henry Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 7390 Cherrywalk Rd., Hebron, MD 21830 Albert Mynes/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sherwood Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 4 10 2010 Salem, VA Signature of Funeral Service Vicer 22Holfoway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Cett 1( A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autops, performed? 2 No page 2 s After this certificate has 1 Yes 2 No Yes 25. Was case referred to edical examiner? completed filled in by the funeral director, 26. Place of Deat heck only one) Be 1 Inpatient 2 I ER/Outpatient 3 I DOA 1 Tes 2 No မှ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easternshore Dr Salisbury MD 21804 910 Mahesha Thimmarayappa
31. Date filed (Month, Day, Year) 32. M.D.

DHMH 17 Rev 7/2009

State

Registrar

APR 07

2010

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| nyam Mamo   | State of Ma<br>1-For State<br>Registrar  | aryland / Departme<br><i>Certifica</i>  |                        |                                      | and          | Menta              | al Hyg         |                                    | 20<br>eg. No.                  | 10            | 12578                                |
|---|--|---|------------------------|--------------------------------------|--------------|--------------------|----------------|------------------------------------|--------------------------------|---------------|--------------------------------------|
| Physician/<br>ledical Examiner  | Decedent's Name (First, Middle,Last)     Binyam Mamo   |   |                        |                                      |              |                    |                | Date of Deat<br>Month<br>March 29, | h<br>Day Yea                   |               | 3. Time of Death<br>0650 hrs         |
|   | 4a. Facility Name (if not institution, give street a 6031 East University Blvd.  | and number)   | 41                     | Ellicott C                           |              | ocation of I       |                |                                    | 4c. County of Howard           | of Death      |                                      |
| Funeral<br>Director   | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last birth  |                        | If Under 1<br>Months                 | Year<br>Days | If Under 2         | 24Hrs.<br>Min. |                                    | th(MM/DD/YYYY                  | Foreign       |                                      |
|   | 577-19-9838 txx M 2  |   | Yrs.                   |                                      |              |                    |                | 9/14/                              | 19/1                           |               | <sup>ntry)</sup> Ethiopia            |
| nd<br>Show any<br>SE.   | MD 10b. County Anne Arundo   | 10c. City, Town o   |                        | n<br>lenton                          | L            |                    |                |                                    |                                |               | 10d. Inside City Limits 1 Yes 2 X No |
| the Maryland 3a or 28a-f show otified at once.  | 10e. Street and Number<br>199 Langdon Farm Circ  | 16  |                        | 10f. Zip Co                          |              | 1113               |                | 10                                 | Og. Citizen of Wh              | nat Count     | ry?                                  |
| r death with th<br>or items 23a c   | 11. Marital Status 12. Wa  | as Decedent Ever in U.S. ned Forces?  |                        | Decedent of                          | of Hispa     | anic Origin        |                | cify Yes or No-                    | - 14. Race<br>White            | - Americ      | an Indian, Black,                    |
| s after deal<br>rral", or its<br>niner muss   | I Never Married 2 A A Married  | Yes 🗶 No<br>ive Year  |                        | Yes 2XX                              |              |                    |                |                                    | Specify:                       |               | ack                                  |
| 2 hour  | 15. Decedent's Education (Specify only higher Elementary/Secondary (0-12)  Col   |   |                        | s Usual Occ<br>st of working<br>Mana | g life. D    |                    |                |                                    | 16b. Kind of Bu                | siness/In     |                                      |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than revent, the Medica or event, the Medica or Be Comple   | 17. Father's Name (First, Middle, Last)  Mamo Yemberberu   |   |                        |                                      |              |                    |                | First, Middle, N                   | I<br>//aiden Surname)          |               |                                      |
| MD 2121 d 2 should be fi lth and Mental I n 27 is marked aumatic event, To Be   | 19a. Informant's Name/Relationship (Type, Prin   |   | •                      | ,                                    |              | and Numbe          | er or Ru       | ral Route Num                      | ber, City or Tow               |               | . ,                                  |
| Baltimore, MD 2 permit Pages 1 and 2 shou Department of Health and N Important: If Item 27 is in injury or other traumatic  | Ethiopia Alemayehu Spouse 199 Langdon Farm Circle Odenton, MD  20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)  Date 20c. Location - crematory or other place) |   |                        |                                      |              |                    |                |                                    |                                |               | own, State                           |
| Baltimore, oemit. Pages I ar Departent of Her Chartent of Her Chartent of Her Chartent in Itel Injury or other tr   | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee  | Meado   | W Ri<br>22. Na         | dge C                                | eme          | tery<br>fFacility[ | 4/.<br>lard    | 3/2010<br>esty Fi                  | Elkrid<br>uneral H             | lge,<br>lome, | MD<br>P.A.                           |
| m ឱ្យ មិនិ<br>Physician   | 23a. Part I. Enter the disease, or complications   | that caused the death. Do not   |                        |                                      |              |                    |                |                                    | s, MD 21<br>est, shock, or hea |               | Approximate Interval                 |
| Examiner  | failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  |   |                        |                                      |              |                    |                |                                    |                                |               | Between Onset and<br>Death           |
| /   | Sequentially list conditions, b. Hangii  |   |                        |                                      |              |                    |                |                                    |                                |               |                                      |
| red<br>nsit<br>Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated  | or as a consequence of):  |                        |                                      |              |                    |                | _                                  |                                |               |                                      |
| tra tra   | events resulting in death) Last Due to (d.   | ir as a consequence or).  |                        |                                      |              |                    |                | ***                                |                                |               |                                      |
| d arigin b  | IF FEMALE: 23c. I  | DED f yes, outcome of pregnancy   |                        |                                      |              |                    |                |                                    | 23d. Date of                   | delivery      |                                      |
| Division of Vital Records, P.O. Box 6876C Hospital or Attending Physician: The law requires that the death certificate A hours after death. Funeral Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the ball Certification: To Be Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  | Live birth 2 Pregnant at time of death 5 Unknown                                |                        | il death<br>er <i>(Specify)</i>      | 3 [          | Ectopic p          | regnand        | cy                                 | Month                          | Da            | ay Year                              |
| s, P.O. Be irres that the de signed by the detached for detached for by Phy   | Part II. Other significant conditions contribu   |   | in the un              | derlying cau                         | use give     | en in Part         | l.             |                                    |                                |               | ne cause of death?                   |
| ords, F<br>w requires to<br>should be of<br>should be defend to   |  |   |                        |                                      |              |                    | - (            | 24a. Was a                         | an 24b. V                      | Vere auto     | ppsy findings available              |
| of Vital Records,  ng Physician: The law requires ther this certificate has been sig- meral director, page 2 should b.  n: To Be Completed  |  |   |                        |                                      |              |                    |                | autop<br>perfor<br>1 Yes           |                                | leath?        | mpletion of cause of                 |
| tal Rectan: The certificate ector, page   | 25. Was case referred to medical examiner? Hospital:   |   |                        |                                      | 10           | f Death (C         |                |                                    |                                | 7             |                                      |
| n of Vi<br>ding Physi<br>After this<br>funeral dir  | 1 Yes 2 No 27. Manner of Death 28a   | Date of Injury 28b. T   | tpatient<br>ime of Inj |                                      |              | at Work?           |                |                                    | Residence 6 v                  |               | Scene                                |
| tending<br>tending<br>death.<br>stor: Af<br>y the fun   | 2 Accident Investigation Ma  | (Month, Day, Year)<br>UND: FOUI<br>or 29, 2010 0630                             | hrs                    |                                      |              | s 2 N              | lo S           | ubject han                         | ged self                       |               |                                      |
| Division or ospital or Attending hours after death.  Inneral Director: After the filled in by the function:  Certification:   | Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Town, State) 6031 E. University Blvd., Ellico   |   |                        |                                      |              |                    |                |                                    |                                |               |                                      |
| the ple lin 7   | one) 2 Medical Examiner: On the  | ne best of my knowledge, dear<br>basis of examination and/or in<br>oner stated. |                        |                                      |              |                    |                |                                    |                                |               |                                      |
| To con  | 29b. Signature and title of certifier  | (M)   |                        |                                      | cense r      |                    |                |                                    | 29d. Date signo<br>March 29, 2 |               | h, Day, Year)                        |
| 100   | 30. Name and address of person who complete Melissa Brassell, MD Assistar  |   | 111 Pe                 | nn Stree                             | et, Bal      | ltimore,           | MD 2           | 1201                               |                                |               |                                      |
| State<br>Registrar  | 31. Date filed (Month, Day, Year) 2010   | 3. Registrar's Signature  | have                   | 1                                    |              |                    |                |                                    | ,                              |               |                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Stanley Edward Moxley 2020 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ xM 2 □ F Months Hours Min 213-20-5844 84 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington County Hagerstown 1 🗆 Yes 2 🔀 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19511 Marsh Circle 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give 1943

Year or Dates. 1946 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Staff Manager Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Stanley D. Moxley Teresa Fredericks Moxley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorna R. Burdick-daughter 19511 Marsh Circle Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Marvin Chapel Cemetery 4-15-2010 Mt. Airy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery FuneralHome North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** accident Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ី Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director. After this certificate I completed filled in by the funeral director, page 2 No 1 Yes \_ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ₩ Naturai 5 Pending 1 Yes 2 🗆 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D28365 4-12-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-3+1 SHAPA. 368 nell

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HARRIET ANN TULLER MECHLING Marc Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memoria Talbo astor Hospita If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days 1 🗆 M 2 🗶 F Months Hours Min. 070-20-6656 1079/1926 Director 83 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location Director or 28a-f MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 222 SOUTH WASHINGTON STREET UNITED STATES 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No
If Yes, Give Black. White, etc. 9 Completed by 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 ၉ HARRY TULLER JEANETTE HOLBROOK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 S. WASHINGTON ST., EASTON, MD EUGENE MECHLING/HUSBAND 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEARE CREMATION 04/01/2010 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 JOHN R. MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final bable Physician/ Cerebra Vascular Acciden disease or condition resulting in death) D Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any hading to immedit cause. Enter Underlying Cause (Disease or linjury Due to the as a prosecutions of the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) ģ signed by detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ cate has been signated by page 2 should by 1 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate h Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify) Hospital 2 No 1 Depatient 2 ER/Outpatient 3 DOA မြ Director; After this in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Alatural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in edical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

g. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

Day

1 Yes 2 No

29d. Date signed (Month. Dav. Year)

21601

Year

1 X Yes 2 □ No

NEW YORK

0940 M

Year

State Registrar

DENNIS M. DESHIELDS, MD 31. Date filed (Month 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 [ 29b. Signature and title of certifier

> 219 S. WASHINGTON ST., EASTON, MD istrar's Signature

DHMH 17 Rev 7/2009

0053110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 20A, FH, TCHD, pha 4/5/10 Amended Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9:50A<sup>M</sup> APRIL 2010 JOHN WALTER MACKNIGHT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8661 CUMMINGS ROAD TALBOT WITTMAN If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 ☐ F Director 09/11/1934 182-26-9630 PA Usual Residence of Decedent r 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No Director MD TALBOT WITTMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Eraminer must be Funeral 8661 CUMMINGS ROAD 21676 U.S.A. Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ▼ Married altimore, Maryland 21215-0036 þ 1 ☐ Yes 2★ No Specify. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TECHNOLOGY project manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ပ WILLIAM MACKNIGHT RUTH PAYNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNNE J. MACKNIGHT/WIFE 8661 CUMMINGS RD., WITTMAN, MD 21676 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION : 04/08/2010 | STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

MD 21601

Impossible Control (1) Immediate Cause (Final HEART FAILURE **Physician** CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ERICARDING CONSTRICTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the ettending physician and be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records,

| 1 |   |   |   |   |
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|   |   |   |   |   |

Registrar

Medical

31. Date filed (Month, Day, Year)

APR 0 5 2010 State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

KOBERS

PATTERSON 800 S. FALBOTST ST. MICHAELS MI) 32 Registrar's Signature

Mahme

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 😽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0057608

29d. Date signed (Month, Day, Year) 4/5/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manth 30<sup>Pay</sup> 2010 ear KEITH YI MERCIER 07:15 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3779 MARVEL DRIVE TRAPPE TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 12/30/1984 1 X M 2 | F Months Hours Min MARYLAND 220-06-4676 25 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No TALBOT TRAPPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3779 MARVEL DRIVE 21673 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Race - American Indian. Black, White, etc. 1 X Never Married 2 Married 2 **X**No 1 Yes 1 Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STUDENT COLLEGE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM J. MERCIER, JR. SOUN YI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BILLY MERCIER/BROTHER 3779 MARVEL DRIVE, TRAPPE, MD 21673 20b. Place of Disposition (Name of cemetery, crematory or other particles). When the company of the cemetery company of the cemetery company of the cemetery cemeters. 20a. Method of Disposition 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State 04/08/2010 EAST NEW MARKET, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA
200 S. HARRISON ST., EASTON, MD 21601 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YXIa Due to ( as a onsequence of) Due to (or as a consequence of): Due to (or as a consequence of)

Physician/ Medical Examiner

and

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certificate

within 24 hours after death.

To the Funeral Director: After this

filled in by

Medical

29a. Certifier

only one)

Physician:

or Attending

Hospital

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certificate be Box 68760

P.O.

of Vital Records,

Division

Physician/

Medical

10a, State

MD

Examiner

**Funeral** 

Director

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ral", or items 23a o Examiner must be 23a

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"natural",

other traumatic event, the Medical

marked other than uld be filed within 7 i Mental Hygiene.

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Page 1 and 2 shment of Health a

Department of Important: If it any injury or o

within 72 hours after death with

3altimore, Maryland 21215-0036

notified at

Director

Funeral

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Completed

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burial-trar attending physician for use as the buria Physician/Medical the ò Completed page 2 : Be ည Certificate: the f

disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? depression 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 🗆 No 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 1 🔲 Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be

28a. Date of injury
(Month, Pay, Year)
Found 30 26:0 28b. Time of Untenouse

28c. Injury at 1 Tes 28d. Describe how injury occurred Hung rect

Easton

4-IMSE/F

Month

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

040120

2010

21601

1 Yes 2 No

State Registrar

Farm Loud veley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |  |                  | 1 - State of Marylal State of Marylal Registrar  | -                                 | irtment of H<br>tificate of D                                 |                                |   | eg. No.          | 10                            | 12583                                      |
|---------------------|--|------------------|--|-----------------------------------|---|--------------------------------|---|------------------|-------------------------------|--|
|                     | Physicia   |                  | 1. Decedent's Name (First, Middle, Last)  ELIZABETH WINDSOR MILLER   |                                   |   |                                | 2. Date of Death                            |                  | Year                          | 3. Time of Death<br>11:10P M               |
| ٠.                  | Medic<br>Examin  |                  | 4a. Facility Name (if not institution, give street and number) WILLIAM HILL MANOR  |                                   | 4b. City, Town, or I  |                                |   | 4c. County       |                               |  |
|                     | Funeral<br>Director  |                  | 5. Social Security Number 221-12-4032  6. Sex 1 □ M 2 ▼ F  86  | last birthday)<br>Yrs.            | If Under 1 Year<br>Months Days                                | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day,<br>MAY 29, | Year)<br>1923    | Countr                        | ace (State or Foreign<br>ry)<br>RYLAND     |
| Т                   | and<br>show<br>at  | ō                | Usual Residence of Decedent           10a. State         10b. County         10c. C  | City, Town or Loc                 | ation   |                                |   |                  |                               | d. Inside City Limits                      |
|                     | Maryla<br>28a-f s  | Funeral Director | MD TALBOT  | TRA                               | APPE  |                                |   |                  |                               | 1 X Yes 2 □ No                             |
|                     | th the<br>3a or<br>the n   | ralD             | 10e. Street and Number   |                                   | 10f. Zip Code   |                                | 1   | 0g. Citizen of W | /hat Count                    | ry?  |
|                     | eath wi  | -une             | 5954 OCEAN GATEWAY  11. Marital Status  12. Was Decedent Ever in U   | J.S. 13. W                        | 21673 Vas Decedent of His Yes, specify Cuban                  | panic Origin? (Spe             | cify Yes or No-                             | USA<br>14. Race  | - America                     | ın Indian.                                 |
| 3036                | led within 72 hours after death with the Maryland Hygiene.  Hygien | by               | 1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.   |                                   | Yes, specify Cuban  Yes 2 No                                  |                                | Rican, etc.)                                |                  | k, White, et                  |  |
| 15-                 | n 72 hour<br>e.<br>an "natu<br>Medical   | Completed        | 15. Decedent's Education<br>(Specify only highest grade completed)   | (Give k                           | ent's Usual Occupa<br>ind of work done du<br>NOT use retired) |                                | ing   | 16b. Kind of Bu  | siness Indi                   | ustry                                      |
| 212                 | within<br>giene.<br>er thau  |                  | Elementary/Seconday (0-12) College (1-4 or 5+)   |                                   | MEMAKER   |                                |   | OWN              | HOM                           | 3  |
| Maryland 21215-0036 | ्र व ज ऱ्  | To Be            | 17. Father's Name (First, Middle, Last)  AGUSTUS WINDSOR   |                                   |   | 18. Mother's Nam               | e (First, Middle, M<br>L MARINE             |                  | )                             |  |
|                     | 2 sho<br>th and<br>7 is r<br>traun   |                  | 19a. Informant's Name/Relationship (Type, Print) <b>BETH M. WEEMS, DAUGHTER</b>  |                                   | g Address (Street ar<br>954 OCEAN                             |                                |   |                  | tate, Zip Co<br>2 <b>1673</b> | ode)                                       |
| Baltımore,          | Page 1 and 3<br>nent of Healt<br>ant: If item 2<br>ury or other  |                  | 1 Rurial 2 Y Cremation 3 Removal from State  | Place of Dispos<br>cemetery, crem | sition (Name of<br>natory or other place<br><b>E CREMAT</b> ) | )                              | Date 72010                                  | 20c. Location -  |                               | vn, State                                  |
| Balti               | permit. Page<br>Department of<br>Important: If<br>any injury of  |                  | 21. Signature of Funeral Service Licensee  Tono R. MERCERE   | 22<br>F                           | Name and Address<br>BLLOWS, E                                 | of Facility IELFENBET          | N & NEWN                                    | IAM FUNI         | ERAL I                        | HOME, P.A.<br>21601                        |
|                     |  |                  | 23a. Part 1. Enter the disease, or complications that caused the dea<br>shock, or heart failure. List only one cause on each line.   |                                   |   |                                | _   |                  |                               | Approximate<br>Interval Between            |
| -                   | Medical  |                  | Immediate Cause (Final disease or condition  | deo                               | nul   | yma                            | my W  | rul              | ·    ]                        | Onset and Death                            |
| فدر                 | Examiner   |                  | Due to (or as a consec   | quence of):                       | In-   | nou                            | morria                                      |                  |                               | 41/11/20                                   |
|                     |  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | uence of):                        | , , ,   |                                |   |                  |                               | Jan y                                      |
|                     | be executed<br>sician and<br>burial-transi   | Examiner         | Cause (Disease or linjury that initiated events c. Due to (or as a consection of the | quence of):                       |   |                                |   |                  | _                             |  |
| 0                   | cate be executed<br>physician and<br>the burial-transit  | edical           | La solida de la solida dela solida de la solida de la solida de la solida dela solida de la solida dela solida de la solida dela sol | 9001100 01/1.                     |   |                                |   |                  |                               |  |
| 09/89               | certificate<br>nding physuse as the  |                  | IF FEMALE:   |                                   |   |                                |   |                  |                               |  |
| Box 6               | death<br>ne atte<br>ed for   | Physician/M      | 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | etal death 3                      | Ectopic pregnancy Other (specify)                             | /                              | 23d. Date of delive                         |                  |                               | ry<br>Day Year                             |
| s, P.O              | requires that the<br>been signed by the<br>should be detach  | by               | Part II. Other significant conditions contributing to death but not re   | esulting in the u                 | nderlying cause give  | en in Part I.                  |   | _/               |                               | e cause of death?                          |
| Records,            | 2 3S   | Completed        | Diofetes Millitar  | 210                               |   | •                              | 24a. Was ar<br>autops                       | 24b. V           | Vere autop                    | sy findings available npletion of cause of |
|                     | The<br>ate h   |                  | Gasho esophogeal le  | efter                             | f 1/150   | ase                            | perform                                     | ned2 c           | leath?                        |  |
| ıtal                | sician: The<br>certificate<br>rector, pag  | o Be             | 25. Was or se referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpution 25   |                                   | Othe  | ce of Death (Checi             |   |                  |                               | -  |
| ot \                | I or Attending Physician:<br>after death.<br>Director: After this certific<br>in by the funeral director,  | te: To           | 27. Man or of Death 28a. Date of injury  | 28b. Time of injury               | 28c. Injury   | at                             | ome 5 $\square$ Reside<br>28d. Describe ho  |                  |                               |  |
| ion                 | tendir<br>Jeath.<br>tor: Aff<br>the ful  | Certificate:     | 2 Accident Investigation 3 Suicide 6 Could not be  |                                   | _M 1□`  | Yes 2□No                       |   |                  |                               |  |
| Division of Vital   | To the Hospital or At within 24 hours after of the Funeral Direct completed filled in by   |                  | 4 ☐ Homicide determined 28e. Place of Injury - At houilding, etc. (Special Special Sp  | ify)                              |   |                                | 28f. Location (Str<br>City or Town          | , State)         |                               |  |
|                     | e Hosp<br>124 ho<br>e Fune   | <b>Nedical</b>   | 29a. Certifier 1   | ion and/or invest                 | igation, in my opinior  | n, death occurred a            | t the time, date and                        | d place, and due | to the cau                    | se(s) and manner stated.                   |
|                     | To th<br>within<br>To th<br>comp   | Σ                | 29b. Signature and title of certifier  | 200 M                             | 29c. License  |                                |   | 9d. Date signed  |                               |  |
|                     | 12   |                  | 30. Name and address of person who completed cause of death (Ite   |                                   |   |                                |   |                  | //                            |  |
| 14                  | Sta  |                  | WILLIAM H. WOOD 501 DUTCH 31. Date filed (Month, Day, Year) 32. Reflistrar's Sign  | a de una                          | 4   | N, MD 2                        | 1601  |                  |                               |  |
|                     | Star   |                  | 31. Date filed (Month, Day, Year)  32. Registrar's Sign  | A A                               | arks  |                                |   |                  |                               |  |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year John David Miller 2010 3:15 P April /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ₹ M 2 □ F 219-42-9008 65 Yrs. Director 1/4/1945 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Medial Examinar matter as sufficient any injury or other traumatic event, In Medial Examinar matter as sufficient any injury or other traumatic event, In Medial Examinar matter as sufficient any injury or other traumatic event, In Medial Examinar matter as sufficient as the sufficient and the sufficient as suffine as sufficient as sufficient as sufficient as sufficient as suf 10d. Inside City Limits 10b, County 10c. City, Town or Location 1 ☐ Yes 2 💢 No Director Maryland | Anne Arundel Crownsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 650 Tailwind Ln. 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ▼ Yes 2 If Yes, Give 2 🗆 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. White 3 Widowed 4 Divorced Year or Dates: VietNam Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Contracting vears Accountant 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Huey Carlyle Miller Margaret E. Russell ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 650 Tailwind Ln., Crownsville, MD 21032 Gina M. Miller/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/9/10 Davidsonville, MD 21. Signature of Augeral Solvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as e consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State

Registrar DHMH 17 Rev 1/2001 29a. Certifier (Check only one)

29b. Signature and title

30. Name and address of person

31. Date filed (Month, Day, Year)

and manner stated

eted cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month) Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 15, Day 2010 Year 1:20P. M Catherine Meath Miller 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Prince George's Renaissance Gardens at Riderwood Village Silver Spring 8. Date of Birth (Month, Day, Jan. 19, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days New York 1920 1 □ M 2√2 F 060-05-5214 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Silver Spring Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 20904 3160 Gracefield Road, ET2211 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Power Patrick Bolger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10926 Pleasant Acres Drive Adelphi, Maryland 20783 19a. Informant's Name/Relationship (Type. Print) Kevin P. Meath -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4/17/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bonard V. Borgwardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland 20705 wordst 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 15 MONTHS Immediate Cause (Final Adenocarcinoma of lung disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 mon 5 ☐ Other (specify) 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

and

physician

attending

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certificate has page 2

After this certific funeral director,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

use as the burial-tran

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law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician:

or Attending

To the Hospital

permit. Page Department of Important: If any injury or once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical Examiner

Completed by

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Certification: To

Medical

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, Ite Medical Examinating the mailtheath and the mailtenance of the mail of

Saltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE

Coronary Artery Disease; Chronic Renal Disease

24a. Was an autopsy nerforme 1 ☐Yes 2 🗓No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2X No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28d. Describe how injury occurred

27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifler (Check only one)

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gracefield Rd Silver Spring MD 20904 31. Date filed (Month

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:44 P M March 2010 Nesbitt Stanley 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Chestertown Kent Heron Point Year If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min. 1**X**] M 2□ F 029-14-3788 87 8/20/1922 Poland Poland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location <sup>10a. State</sup>land Chestertown Kent 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21620 421 Heron Point 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2x No white WWII Specify Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Defense Industry Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Nieradka Stanley Nabreski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 396, Brownsville, VT 05037 Christopher S. Nesbitt - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Baltimore Crematory 4/5/2010 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. STAGE ALTHEIMFDS Immediate Cause (Final CILL years h? nown ilable

Physician /Medical Examiner Examiner

Physician

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

23a or

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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev

72 hours after

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

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event, the Medical Evaruinar must be notified at

the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar ned by the a has 24 hours after deat Funeral Director; completely filled in by the

Be Completed by Physician/Medical

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **APR 0 7 2010** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Helen Andrews Noble M.D.

Division of Vital Records, P.O. Box 68760,

| disease or condition  | - END STROL HOUTE INCOME   |   | 1000  |
|---|--|---|---|
| resulting in death)   | Due to (or as a consequence of):   |   |   |
| Sequentially list conditions,   | b  |   |   |
| Cause (Disease or injury that initiated events resulting in death) Last                 | c Due to (or as a consequence of):   |   |   |
|   | d  |   |   |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy  1   | N   | Date of delivery<br>Month Day Yea   |
| Part II. Other significant conditions   | contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use co<br>1 □ Yes 2 No               | ontribute to the cause of deat 3 ☐ Probably 4 ☐ Unk                                   |
|   |  | 24a. Was an autopsy performed? 1 Yes 2 No             | o. Were autopsy findings ava<br>prior to completion of caus<br>death?<br>1 □Yes 2 XNo |
| 25. Was case referred to medical  | 26. Place of Dea   | th (Check only one)                                   |   |
| examiner?<br>1  Yes 2 X No  | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing H               | ome 5 ☐ Residence 6 ☐ C                               | Other (Specify)   |
| 27. Manyer of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat                       | 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?                       | 28d. Describe how injury occ                          | urred   |
| 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine                                     |  | 28f. Location (Street and Nur<br>City or Town, State) | mber or Rural Route Number  |
| 29a, Certifier 1 Certifying   | Physician: To the best of my knowledge, death occurred at the time, date and place | e, and due to the cause(s) and                        | manner as stated.   |

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

122 Speer Rd, #5, Chestertown, MD 21620

0041587

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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State Registrar

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death <sup>Day</sup> 2010 Month Physician/ 3:15\_A M Apri] Philip Hugus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda 5606 Jordan Road if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours 1 🕅 M 2 🗆 F Months ·Year) 959 Washington, DC 50 Director 578-88-9626 Usual Residence of Decedent or 28a-f shown notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director 1 Yes 2 No Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number ò "natural", or items 23a o Funeral with 1 5606 Jordan Road 20816 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2x No Specify Specify. 3 🗌 Widowed 4 🗎 Divorced Completed White Year or Dates In Mental Hygiene.

S marked other than "nature immatic event, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5<u>+</u> Law Firm Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ၉ Neff Marianne Huqus Philippe Monsabre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2.
Department of Health an Important: If item 27 is ... iniury or other tra .s 18009 Lafayette Drive Olney, Maryland 20832 Lisa N. Kalbacher/sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/7/2010 Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Thomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 uanita 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Malignant Carcinoid of the Colon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last -burialattending physician for use as the burial Medical P.O. Box 68760 IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown g Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been si should I 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has I page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 XNo 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending X Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse, Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 29c. License number ೭ April 6, 2010 DC19655

Registrar
DHMH 17 Rev 7/2009

State

10

NW Washington, DC 20007

3800 Reservoir Rd.

legistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

John Marshall,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1407 Michael VINCENT 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Days Yrs. Maryland 54 **Director** 215-62**-**2083 12/27/1955 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. It fitem 27 is marked other than "natural", or items 23a or 28a-f show or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Wicomico Salisbury MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? must be USA 26907 Blackhorse Run 21801 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No 1973—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify þ Specify: 3 Widowed 4 Divorced 1976 Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Inventory/materials Manager Spartech Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Regina Jacqueline Barclay ဂ္ Floyd Orr, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Marie Orr/ Wife 26907 Blackhorse Run - Salisbury, MD 21801 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Green Acres Memorial Park: 4/10/2010 4 Donation 5 Other (Specify) Salisbury, MD 21. Sign sure of Funeral Service Licensee 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus Do not enter the mode of dying, such as cardiac or respiratory arrest at caused the deat Immediate Cause (Final **Physician** Sastrointestinal Bleeding disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Carcinoid Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Pesidence 1X Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) after death. Director: After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide City or Town, State) vithin 24 hours a to the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R95-000 2010

Registrar

State

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mario

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  | -              | State of Ma  | _                                  | -   | rtment of H<br>tificate of D            |                           |  | 2 U                           | 0                       | 125                             | 89         |
|----------------------------|--|----------------|--|------------------------------------|---|---|---------------------------|--|-------------------------------|-------------------------|---------------------------------|------------|
|                            | _  |                | 1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)                                     |                                    | Ceri  | incare or E                             | , cairi                   | 2. Date of Dear                            |                               |                         | 3. Time of De                   | eath       |
|                            | Physicia<br>Medic  |                | Moones Pirasteh  |                                    |   |   |                           | Month 3/3                                  | 1/2010                        | Year                    | 5p                              | om M       |
|                            | Examin   |                | 4a. Facility Name (if not institution, give street and number)   |                                    |   | 4b. City, Town, or                      |                           | ı  | 4c. County                    |                         | 1 1                             |            |
| مد                         | <b>'</b>   |                | 1330 Waterbury Rd.  5. Social Security Number 6. Sex 7. Age  | An ura laat hirth                  | Crownsville In yrs. last birthday) If Under 1 Year   If Under 24 Hr |   |                           |  |                               |                         | unde1                           | foreign    |
|                            | Funeral<br>Director  |                | 5. Social Security Number 0. Sex 1 □ M 2 🔀 F 7. Age  |                                    | Yrs.  | Months Days                             | Hours Min.                | 8. Date of Birth (Month, Day, 3/21/1)      | Year)<br>914                  | Coun                    | try) Iran                       |            |
| _                          |  |                | Usual Residence of Decedent  |                                    |   |   |                           | 1 37 7                                     |                               |                         |                                 |            |
|                            | yland<br>-f sho<br>ed at   | Director       | 10a. State 10b. County MD Anne Arundel   | 10c. City, Town                    | or Loc  | ation<br>Crowns                         | viile                     |  |                               | 1                       | 0d. Inside City I               |            |
|                            | r 28a<br>notifi  | Dire           | 10e. Street and Number   |                                    |   | 10f. Zip Code                           |                           |  | 10g. Citizen of What Country? |                         |                                 | 121110     |
|                            | with the 23a c   | Funeral        | 1330 Waterbury RD.   |                                    |   | 210                                     | 032                       |  | USA                           |                         |                                 |            |
|                            | items<br>items<br>er mi  | F              | 11. Marital Status  12. Was Decedent E Armed Forces?   | ver in U.S.                        |   | as Decedent of Hi                       | spanic Origin? (S         |  | 14. Race                      | e - Americ<br>k, White, |                                 |            |
| 36                         | after o  | d by           | 1 Never Married 2 Married 1 Yes 2 😾  | No                                 |   | ☐ Yes 2 🛣 No                            |                           | ,  | Specify:                      | T 77                    | ite                             |            |
| 21215-0036                 | nours<br>latura<br>ical E  | Completed      | 15. Decedent's Education   |                                    |   | ent's Usual Occupa                      |                           | 1  | 16b. Kind of Bu               | siness Inc              | dustry                          | - 1        |
| 212                        | in 72 h<br>e.<br>tan "n<br>Medi  | duc            | (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5                                   |                                    |   | ind of work done d<br>NOT use retired)  | luring most of wo         | rking                                      |                               |                         | •                               |            |
| 7                          | ygiene<br>ygiene<br>her th   | a)             | 5+   |                                    | Te  | acher                                   |                           |  | Educa                         |                         | 1                               |            |
| Maryland                   | ntal H<br>red ot<br>eed ot   | To B           | 17. Father's Name (First, Middle, Last)  |                                    |   | UNK                                     | 18. Mother's Na<br>Khavar | me (First, Middle, I                       | Maiden Surname                | )                       | UNK                             |            |
| ĮŽ.                        | ould the mark mark   |                | Abraham  19a. Informant's Name/Relationship (Type, Print)  | 19b.                               | Mailin  | g Address (Street a                     |                           | ıral Route Number,                         | City or Town, S               | tate, Zip (             | _                               |            |
| Š                          | d 2 sh<br>alth an<br>n 27 is<br>ertrau   |                | Darvish Doorandish So  |                                    |   | Waterbur                                |                           |  |                               |                         |                                 |            |
| Baltimore,                 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                 |                | 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State   | 20b. Place of cemeter              | Dispos<br>y, crem   | sition (Name of<br>eatory or other plac |                           | Date                                       | 20c. Location -               | •                       |                                 |            |
| ţ                          | t. Pag<br>tment<br>rtant:<br>njury c   |                | 4 ☐ Donation 5 ☐ Other (Specify)   | Hiller                             |   | Cemeter                                 |                           |  | Annapol:                      |                         |                                 |            |
| Bal                        | permii<br>Depar<br>Impor<br>any ir   | . 3            | 21. Signature of Funeral Service Licensee  |                                    | 22.   | Name and Addres                         | ss of Facility<br>Har     | desty Fu                                   | neral Ho                      | ome,                    | P.A.                            |            |
|                            |  |                | 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line | the death. Do no                   | ot ente   | Ridgely<br>r the mode of dying          | g, such as cardia         | nnapolis<br>or respiratory arre            | <del>, MD ZI</del><br>est,    | +UI                     | Approximate<br>Interval Between | on.        |
|                            | Physician/   | X 16           | Immediate Cause (Final disease or condition  | 21-A#                              | he  | ic 1                                    | 1                         |  |                               |                         | Onset and Dea                   |            |
|                            | Medical Examiner   |                | was ultime in death)   | a consequence o                    | of):  | to do                                   |                           | 100  |                               |                         |                                 |            |
|                            |  | er             | Sequentially list conditions, b. Due to (or as a   | -                                  |   |   |                           |  |                               |                         |                                 |            |
|                            | ted<br>I<br>Insit  | Examiner       | cause. Enter Underlying Cause (Disease or iinjury  |                                    |   |   |                           |  |                               |                         |                                 |            |
|                            | execu<br>an and<br>rial-tra  | I Ex           | that initiated events resulting in death) Last C. Due to (or as a  | a consequence o                    | of):  |   |                           |  |                               |                         |                                 |            |
| 09                         | cate be executed<br>physician and<br>s the burial-transit  | edical         | d  |                                    |   |   |                           |  |                               | -                       |                                 |            |
| 687                        | eath certifica<br>attending p  |                | IF FEMALE: 23c. If yes, outcome  | of pregnancy                       |   |   |                           |  | 23d Dat                       | te of delive            | erv                             |            |
| Box 68760                  | eath c<br>atten  | iciar          | 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No  25c. 1  Yes, outcome 1  Live Birth 4  Pregnant a        | 2 □ Fetal death<br>t time of death | 3 L<br>5 L  | Ectopic pregnand Other (specify)        | ;y                        |  |                               | nth                     | Day Yea                         | ır         |
| О.                         | the di<br>by the<br>tachec   | by Physician/M | g ☐ Unknown  |                                    |   |   |                           |  |                               |                         |                                 |            |
| , P.O.                     | requires that the de<br>been signed by the<br>should be detached   | by             | Part II. Other significant conditions contributing to death b  | ut not resulting ii                | n the u   | nderlying cause giv                     | /en in Paπ I,             |  | bacco use contr<br>es 2 No    |                         |                                 |            |
| rds                        | equire   | eted           |  |                                    |   |   |                           | 24a. Was a                                 |                               |                         | psy findings ava                | - 1        |
| eco                        | sician: The law i<br>certificate has b<br>lirector, page 2 s   | Completed      |  |                                    |   |   |                           | autop<br>perfor                            | sy med?                       | orior to co<br>death?   | mpletion of caus                |            |
| E<br>R                     | an: Th<br>tificate<br>tor, pa  | Be Co          | 25. Was case referred to medical   |                                    |   | 26. Pl                                  | ace of Death (Che         | 1 Yes                                      | 2 🗗 No                        | 1 🗌 Yes                 | 2 L No                          |            |
| VII.                       | nysicia<br>lis cer<br>direc  | To B           | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpati  | ent 2 🗆 ER/Ou                      | tpatien   | t 3 🗆 DOA Othe                          | er:<br>4 🗆 Nursing        | Home 5 Resid                               | ence 6 🗆 Othe                 | er (Specify             | )                               |            |
| of                         | ing Ph<br>ifter th<br>uneral   |                | 27. Manner of Death 28a. Date of inju<br>1 Natural 5 Pending (Month, Day   | ry 28b. T<br><i>y, Year)</i> ir    | îme of<br>njury   | 28c. Injun<br>work                      | y at                      | 28d. Describe ho                           | ow injury occurre             | ∍d                      |                                 |            |
| sior                       | death<br>stor: A   | Certificate:   | 2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Inju  | ırv - At home, far                 | rm. stre  | M 1 Ll                                  | Yes 2 No                  | 28f 1 ocation (S                           | treet and Numbe               | er or Bura              | Route Number                    |            |
| Division of Vital Records, | al or A<br>s after<br>I Direct   |                | 4 Homicide determined 200. Flace of IIII   |                                    | ,   | ,,,                                     |                           | City or Town                               |                               |                         |                                 |            |
| _                          | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi | Medical        | 29a. Certifier 1 Certifying Physician: To the best of (Check 2 ☐ Medical Examiner: On the basis of e                   | my knowledge, o                    | death o   | occured at the time                     | , date and place,         | and due to the cau<br>at the time, date ar | use(s) and manne              | er as state             | ed.<br>use(s) and mann          | er stated. |
|                            | the P<br>thin 24<br>the F  | Me             | only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier                                  |                                    |   |   | e time, date and p        | ace, and due to the                        |                               | anner as st             | ated.                           |            |
|                            | <b>5</b> ≥ <b>5</b> 00   |                | Darush Dare  | noles                              | M   | 0 -                                     | 3749                      |  | 29d. Date signed              |                         | _ 3,, . 60,                     |            |
|                            | ^  |                | 30. Name and address of person who completed cause of d  | eath (Item 23a) (                  | Type, P   |   | 2711                      |  |                               |                         |                                 |            |
|                            | Z,   |                | Dr. Darvish Doorandish 32  | 5 Hospit                           | tal   | Dr. Ste                                 | 201 Gler                  | Burnie,                                    | MD 210                        | 61                      |                                 |            |
|                            | Sta<br>Registr   |                | 31. Date filed (Month, 035 2010 APR 05 2010  | ar's Signature                     | art   |   |                           |  |                               |                         |                                 |            |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1815 hrs Medical Examiner Plowman April 12, 2010 Carolyn 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 536 Moorings Circle Arnold 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. **Funeral** 5. Social Security Number 6. Sex Age (In yrs. last birthday) oreign Country) Months Days Hours Director 221-32-5091 Jul. 21, 1951 TN 1 M 2 X F 58 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ī 10a. State Anne Arundel Arnold 1 Yes 2 X No MD 28a-f show must be notified at once, mit. Pages I and 2 should be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21012 USA 536 Moorings Circle Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes White 3 Widowed Give Year Yes 2 X No specify: Specify: 4 Divorced the Medical Examiner ð 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Office/Home Administrative/Homemaker MD 21215-0036 1 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clayton Hill Margaret Hoover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hanover, MD 21076 Quinn Dewitt Sanders/Son 54 Greenknoll Blvd. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, crematory or other place) April 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory 2010 Donation 5 Other Specify: 21 Signature of Funeral Service Lice see 22 Name and Address of Facility Farranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Severna Park or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval nter the disease, Physician Between Onset and failure. List only one cause in each line /Medical Death Atherosclerotic cardiovaascular disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami Discose or injury that initiate Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED icate has been signed by the attending physician page 2 should be detached for use as the burial AMENDED 3a,27,PII, per ME G902 4/23/10 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown <u>۾</u> Cirrhosis of liver Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? ✓ Yes 2 No death? 2 No 1 🗸 this certificate Yes To the Hospital or Attending Physician within 24 hours after death.

To the Funeral Director: After this certifi reral Director: After this certifi filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. April 13, 2010 0 30. Name and address of person who completed cause of death (Item 23a) **Assistant Medical Examiner** 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

31. Date filed (Month, Day, Year) State Registrar

32. Redistrar's Signature

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nafeesa Khatoon Qureshi April 11<sup>ay</sup> 201<sup>o</sup> 7:40A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 405 Samuels Spring Court Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral**  Date of Birth (Month, Day) January 1,1929 Months Days Hours 1 □ M 2 □ F Yrs India Director 213-65-4564 81 Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show Maryland Montgomery Silver Spring 1 □Yes 2X No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20905 United States 405 Samuels Spring Court Funeral death 1 7 is marked other than "natural", or items traumatic event, the Weden Examiner of 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: ð Asian 3 XWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Batool Khatoon Abdul Razzaq 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is other tra 405 Samuels Spring Court Silver Spring, MD 20905 Ashraf Qureshi -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any Injury or otl once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/12/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA Word 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the country of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and is the burial-transit law requires that the death certificate be executed Exami Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 27 No
9 Unknown Month Day Year 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease; Hypertension, Congestive 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate | 1 □Yes 2 XNo 1 ☐ Yes 2 ¥☐ No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) within 24 29b. Signatur tle of o 29c. License number 29d. Date signed (Month, Day, Year) April 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Asif S. Qadri, M.D. MCC Medical Clinic 15200 New Hampshire Avenue Silver Spring, MD 20905 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**ORIGINAL** 

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2010 Physician/ April  $A^{M}$ Doris Louise Ridenour 5:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Williamsport Nursing Home Williamsport Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Nov • 22, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Maryland 220-46-0624 Director 89 Ĩ920 Usual Residence of Decedent 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 East Magnolia Ave. 21742 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William permit. Page 1 and 2 should be Department of Health and Menf Important: If item 27 is marke any injury or other traumatic of R. Eckstine Ethe1 Spessard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Ridenour / Daughter E. Magnolia Ave., Hagerstown, Maryland 21742 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/14/2010 Hagerstown Maryland Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel Sign ur - f Funeral Service Icensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ SEPTICEMIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SACRAL DECUBITUS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician a d be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 N this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 TNo 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours at er death.

To the Funeral Director: A completed filled in by the fi hours at er death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Pollowe D33700 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6. Howe 154 N ARTIZAN ST WILLIAMSRORT

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0049 SCOTT, HAROLD S. JR. 10 04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICOMICO Conte SALISBUTU TENINSYUM REGIONAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 **X** M 2 □ F 12/24/1952 Maryland Director 214-30-8494 57 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Maryland Salisbury 1 Yes 2X No 10e. Street and Number 10f. Zip Code items 23a or ner must be n ò 10g. Citizen of What Country? Funeral 21801 27273 Patriot Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Machinery Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold S. Scott Mary E. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kasey Scott-Windsor (Daughter) 27273 Patriot Drive - Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Wicomico Memorial Park 4/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Signature Characteristics Service Licens 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, H. Bradshaw, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Kulmon ANG (Tylespetensia Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) conclomAtos is Examiner Magazares Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) OP Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 2 No Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) H54827 of death (Item 23a) (Type, Print)

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Registrar DHMH 17 Rev 7/2009

State

MITENTE

31. Date filed (Month, Day, Year)

GUTERMAN

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Mae Shores 2157 2610 04 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death REGIONAL Medicax VICOMICO PENINSULA 5A436414 8. Date of Birth (Month, Day, Oct. 8, If Under 1 Year | If Under 24/Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🕱 F Hours Country)
Maryland Director 214-32-6413 74 1935 Usual Residence of Decedent 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho upy or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2404 Paleo Lane 21801 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 🗌 Widowed 4 🗌 Divorced white Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Sigsbee Shores Sadie Frances Downes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna S. Huntington (Sister) 2404 Paleo Lane Salisbury, MD 21801 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H Important: If 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 04-07-2010 Salisbury, Maryland 21. Signature of Funeral Service Licenses Name and Address of Facility
Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate se on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No ρ Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen 12 Coronary Artry Bypas Jungery 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Drobuty Millite certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 044069 Su of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 21822 106 MILFORD CAMBURY M (SOM) 31. Date filed (Mont)

Registrar DHMH 17 Rev 7/2009

State

32. Jegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley Rosezellah Slavens Month Year 0835 M 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL TENINS4UA 5A C1364 A edical HICOMICO If Under 1 Year If Under 2 8. Date of Birth Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏿 F Days 278-38-2504 Hours 0112311937 Michigan 73 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State filed within 72 hours after death with the Maryland Director Delmar Sussex Delaware 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Fuller Place, Apt. 6 19940 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 ☐ Widowed 4 ☐ Divorced white Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12housewife domestic Be At. Page 1 and 2 should be artment of Health and Mental Hy artment of Health and Mental Hy artment of them 27 is marked of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Ford Russell Trouten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Fuller Place, Apt. 6, Delmar, DE 19940 Rev. Larry E. Slavens/spouse Baltimore, Important: If item any injury or othe 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Beaver town God s 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 10 2010 | Beavertown, PA Missionary Cemetery nature of Funcial Service Licensee 22 Holloways Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 David A. Wompson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final PSEU do moyas Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signard by the attending housing more AMENOGUIVOHO vdo vascu lan diseux sate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of doath IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) In the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 1No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 Wo 은 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be

State Registrar

Medical

4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifie

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an a hesu

31. Date filed (Month, Day

determined

Manue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UNITEDUD St

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32014

28f. Location (Street and Number or Rural Route Number,

415710

504 13. Salisbury uno 21804

29d. Date signed (Month, Day, Year)

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 4/2/2010 Patricia Eileen Swift 315am 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 1838 Generals Hwy. Annapolis Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 M 200 Months Hours Min. (Month, Day, Year 5/14/195 222-38-8236 58 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Anne Arundel Annapolis 1 Yes 2xXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21401 USA 1838 Generals Hwy. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Decedon Armed Forces? □ Yes 242 No Black, White, etc. 1XXNever Married 2 ☐ Married White 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bio Tech Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Helen E. Morreale Eugene P. Swift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21401 Sharon Swift Sister 1838 Generals Hwy. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 4/5/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses D 21401 Approximate

permit. Page 1 and 2 should be filed within 72 i. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n; any injury or other traumatic event, the Medic once. Ph\_sician/ Medical

Physician/

Medical

10a. State

MD

Director

Funeral

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**Examiner** 

**Funeral** 

Director

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"natural"

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

ng physician and as the burial-transit

the attending physician

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page 2 s

this certificate has

within 24 hours all er death.

To the Funeral Director After this certific completed filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine Physician/Medical Completed by Be ၉ Certificate:

Medical

| Jal n  | 60/1        | (                            | 12     | Ridgely           | Ave.        | Annapolis,                  | M |
|--|-------------|------------------------------|--------|-------------------|-------------|-----------------------------|---|
| 23a. Part 1. Enter the disease, of shock, or heart failure. List               |             |                              |        |                   | such as car | diac or respiratory arrest, |   |
| Immediate Cause (Final disease or condition resulting in death)                | <b>f</b> a  | Due to (or as a consequence  |        | mor               |             |                             | _ |
| if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury | b. =        | Due to (or as a consequence  | e of): |                   |             |                             |   |
| that initiated events resulting in death) Last                                 | c. <b>_</b> | Due to (or as a consequence  | e of): |                   |             |                             |   |
|  | d           |                              |        |                   |             |                             |   |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months?                   | 23c.        | If yes, outcome of pregnancy |        | Ectopic pregnancy |             |                             | 1 |

River and Park 23d. Date of delivery Pregnant at time of death 5 U Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exampliner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner as stated. Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only bne 29b. Signa

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #5 TCHD 04/01/10 pha 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 AGOSTINO TED SOLDANO 30<sup>ay</sup> 2010 9:50  $\mathbf{P}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TALBOT WILLIAM HILL MANOR EASTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months 1 X M 2 □ F Hours Min. 219-05-49-4 0670371922 WASHINGTON, DC Director 87 Yrs Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director 1X Yes 2 No MD TALBOT EASTON iral", or items 23a or 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 700 PORT STREET #304 21601 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 🗶 No "natural". Specify: WHITE 3 Widowed 4 Divorced Completed event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working other than Elementary/Seconday (0-12) College (1-4 or 5+) INDUSTRIAL REPRESENTATIVE UTILITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked pe. AGOSTINO TED SOLDANO, SR. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. MARIA ASPESLAGH other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEMARY SOLDANO/WIFE 700 PORT ST. #304, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 03/31/2010 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 2. Name and Address of Facility
ELLOWS, HELFENBEIN &
00 S. HARRISON ST., HOME, PA JOHN R MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate enval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner teru oclore Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Yes 2 No the g Unknown ģ signed t Part II. Other significant condition death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ila 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? in 24 hours after deaun. The Funeral Director: After this of noleted filled in by the funeral dire Other: ြုင 2 1No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death Certificate: 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 - Pending 1 / Natural 1 Tes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

WILLIAM H. WOOD, MD

31. Date filed (Month Day Year) 1 2010

istrar's Signature

501 DUTCHMAN'S LN., EASTON, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April <sup>2</sup>2010 5 William B. Schaeffer 6:27 pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1207 Turkey Point Road Edgewater If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 12/05/1919 Pennsylvania 161-07-0792 90 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State hours after death with the Maryland Director Anne Arundel Edgewater 1 Nes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21037 United States 1207 Turkey Point Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married ð Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Year or Dates. 1944-46 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Elementary School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever William Grover Cleveland Schaeffer Mary Elizabeth Lewis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Turkey Point Road, Edgewater, Maryland 21037 Demetria Schaeffer/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🗀 Cremation 3 🗶 Removal from State Bucks County Crematories 04/07/2010 Levittown, Pennsylvania 4 Donation 5 Other (Specify) <sup>22. Name and Address of Facility</sup>George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md. 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 126 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a d be detached f 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopu performed 2 certificate has 1 Yes 2 No 1 🗆 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No 4 
Nursing Home ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this o 27. Manner of Death 28a. Date of injury (Month, Day, Year) Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury thin 24 hours after death.

the Funeral Director: Af
empleted filled in by the fu 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 808 Landmark Drive, Ste. 128 Glen Burnie,

Registrar

31. Date filed (Month, Day, Yea

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#29D Per PHY State of Maryland / Department of Health and Mental Hygiene = State Registrar 4/9/10 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 03:20 PM WALTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1915 Copeland St. Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F oct 31 I937 Days Hours 219-34-0267 72 Maryland Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 701 Glenwood St. Apt 619 USA 21401 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XNo
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Inn al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 Waiter Restaurant <u>11th</u> perint. Page 1 and 2 should be filed w Decartment of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Crowner Clayton Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel Savoy(Daughter) 1915 Copeland St. Annapolis, Md. 21401 20b. Ente of Disamin CNarte of 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-9-10 Cedar Bluff Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2 Manue and Recessor Fability Sons Mortuary, P.A. . Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ... ch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ month Medical resulting in death) Due to (or as a con requence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 **2**0 6 XOther (Specify) DAUGHTER'S မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Division of Vital Records, P.O. Box 68760 this certificate has been signed by the atteral director, page 2 should be detached for funeral director,

27. Manner of Death

Natural

Accident

Suicide

4 Homicide

29a. Certifier

Certificate:

Medical

Maryland 21215-0036

Baltimore,

To the Funeral Director: After completed filled in by the funer within 24 hours a

State Registrar

5 Pending

Investigation

determined

6 Could not be

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

MID LEGER

31. Date filed (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieneo O. L. O.

|             |  |                   | 1-   | For<br>State<br>Registrar   |  | State                                | Of Ivial yie   |                                     | rtificate of   |   |   | Reg. No.                                     | J 26UU   |
|-------------|--|-------------------|--|---|--|--------------------------------------|--|-------------------------------------|--|---|---|--|--|
|             | Physic   | ian               |  | ecedent's Name  |  | le, Last)                            | RRT  |                                     |  |   | 2. Date of Dea<br>Month                     | Day Yea                                      |  |
| A. Car      | /Medi<br>Examii  |                   | 4a. F  | acility Name (If  | not institutio                           | on, give street and                  | number)  |                                     | 4b. City, Town, o  | or Location of Deat                       | MARCH 2                                     | 4c. County of De                             | 2214 P M   |
| 1           |  |                   |  | Cial Security Nu  |  | MEDICAL<br>6. Sex                    |  | us to at high day.                  | ANNAPO   |   | 9 Date of Birth                             | ANNE AI                                      | RUNDEL<br>sirthplace (State or Foreign                                   |
|             | Funeral<br>Director  |                   | Į.   | 191–30–9  |  | 1 <b>X</b> M 2 □ F                   |  | rs. last birthday)<br>Yrs.          | Months Days  | Hours Min.                                | (Month, Day                                 | , Year)<br>, 1939 PEN                        | Country)   |
|             | land<br>ow   |                   |  | I Residence of<br>State   | Decedent<br>10b. County                  | ,                                    | 10c.   | City, Town or Lo                    | ecation  |   |   |  | 10d. Inside City Limits  |
|             | eath with the Marylans 23a or 28a-f show   | ctor              |  | MD  | TAL                                      | вот                                  |  | EASTO                               | Ŧ  |   |   |  | 1 <b>X</b> Yes 2□No  |
|             | with the   | Funeral Director  |  | Street and Num  |  | YTATE                                |  |                                     | 10f. Zip Code  |   |   | 10g. Citizen of What (                       | Country?   |
|             | ms 23  | nera              | _  | 29171 P   | LN VAK                                   | 12. Was De                           | ecedent Ever in  | U.S. 13.                            | 2160<br>Was Decedent of H<br>If Yes, specify Cub             |   | Specify Yes or No-                          | USA<br>14. Race - An                         | nerican Indian,  |
| 5-0036      | s 1 and 2 should be filed within 72 hours after death with the Maryland Fhealth and Mental Hygiene. If the Last is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Rectan for most be notified at   | d by Fu           | 1  | ☐ Never Marrie  |  | ried 1 □Ye                           | Forces?<br>s 2 X No<br>Give<br>Dates:                        | 1                                   | if Yes, specify Cub<br>1 □Yes 2 <b>X</b> No                  |   | to Hican, etc.)                             | Black, Wh                                    | WHITE  |
| 15-(        | n 72 hours<br>"natural",<br>edicel Exe   | olete             |  | (Speci  | fy only highe                            | nt's Education<br>est grade complete |  | (Give                               | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most of wor                        | rking                                       | 16b. Kind of Busines                         | s/Industry   |
| 2121        | d withi<br>giene.<br>er thar   | Completed by      | Ele  | ementary/Secon  | idary (0-12)                             | _                                    | (1-4or 5+)   |                                     | JDGET ANA  |   |   | FEDERA                                       | L GOVERNMENT   |
| and         | be file<br>ntal Hy<br>ed oth   | Be                |  | ather's Name (  |  |                                      |  |                                     |  |   |   | Maiden Surname)                              |  |
| Maryland    | should be filed within and Mental Hygiene. s marked other than aumatic event, the manatic event, the manatic event.  | မ                 |  | OHN GEO   |  | ship (Type, Print)                   |  | 19b. Maili                          | ng Address (Street   |   |   | FEATHERER r, City or Town, State             | , Zip Code)  |
|             | and 2 s<br>ealth ar<br>n 27 is<br>ier trau   |                   | M  | ARGARET   | F. T.                                    | APPERT, V                            | IFE  | 1                                   | 171 PIN  |   |   | · ·  |  |
| Baltimore,  | Pages<br>ment o<br>ant: If<br>ury or   |                   |  | Method of Disp<br>I ☐ Burial 2 🕱<br>I ☐ Donation  | Cremation                                | 3 □ Removal fro<br>Specify)          | m State  | cemetery, crei                      | esition (Name of matory or other place  E CREMAT             |   | Date 1/2010                                 | 20c. Location - City of STEVENSV             |  |
| Balt        | permit. Departr Importa any inju   |                   | 21. 8  | Signature of Fur  |  |                                      | _  | 2:<br><b>F</b>                      | 2. Name and Addre  | ess of Facility<br>HELFENBE               | n & newn                                    | iam funerai                                  | L HOME, P.A.   |
|             | Physician<br>/Medical<br>Examiner  | ner               | Imm<br>dise<br>resu                              | shock, or hear<br>ediate Cause (F<br>ase or condition<br>Iting in death)  | e disease, o<br>t failure. List<br>Final | b                                    | t caused the de  | eath. Do not en                     | OO SOUTH er the mode of dyi                                  | ng, such as cardia                        | c or respiratory ari                        | EASTON, l                                    | Approximate Interval Between Onset and Death                             |
| 68760,      | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | cal Examiner      | cause. E<br>Cause (I<br>that initia<br>resulting | uentially list con<br>, leading to immone. Enter Under<br>se (Disease or in<br>nitiated events<br>ting in death) Li | njury<br>ast                             | c                                    | o (or as a conse   | equence of):                        |  |   |   |  |  |
| . 68        | ertificat<br>ing phy<br>e as the   | Medical           | IE EE  | EMALE:  |  | u                                    |  |                                     |  |   |   |  |  |
| O. Box      | the death ce<br>y the attend<br>ched for use   | Physician/        | 23b.   | Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown   | nonths?                                  | 1 ☐ Liv                              | outcome of preg<br>e birth 2□Fe<br>egnant at time o<br>known | etal death 3                        | Ectopic pregnand Other (specify)                             | су  |   | 23d. Date of o<br>Month                      | delivery<br>Day Year   |
| s, P.       | as that<br>gned b  | by Pt             | Part I   | l. Other signific   | cant conditi                             | ons contributing to                  | death but not re   | esulting in the u                   | nderlying cause giv  | ven in Part I.                            | 23e. Did to                                 | bacco use contribute                         | to the cause of death?   |
| ord         | require  |                   |  |   |  |                                      |  |                                     |  | ·   |   |  | Probably 4 Unknown   |
| al Records, | n: The law<br>ficate has b<br>if, page 2 s   | Completed         |  |   |  |                                      |  |                                     |  |   | 24a. Was a<br>autop<br>perfor<br>1 □ Yes    | sy prior t<br>med? death<br>2 XNo 1 □ Yo     | autopsy findings available<br>o completion of cause of<br>?<br>es 2 □ No |
| f Vital     | ysicla<br>is certi<br>directo  | o Be              | е  | Vas case referre<br>xaminer?<br>□ Yes 2\□(1)  |  | Hospital:                            | Ínpatient 2  | ☐ ER/Outpatier                      | nt 3 DOA Oth   | oer.                                      | ath <i>(Check only or</i><br>Home 5 □ Resid | <i>ne)</i><br>ence 6 ☐Other <i>(Si</i>       | pecify)  |
| n of        | ing Ph<br>After th<br>uneral   | on: T             |  | lanner of Death   | 5 ☐ Pendir                               | 28a. Da                              | te of Injury<br>onth, Day, Year)                             |                                     | f 28c. Inju  | ry at<br>1k?                              |   | ow injury occurred                           |  |
| Division    | l or Attend<br>after death<br>Director; /<br>I in by the f   | Certification: To | 3  | ☐ Accident<br>☐ Suicide<br>☐ Homicide   | investi<br>6   Could<br>detern           | gation<br>not be 28e. Pla            | ce of Injury - At<br>Iding, etc. (Spe                        | home, farm, str                     | M 1 □<br>eet, factory, office                                | ]Yes 2□No                                 | 28f. Location (S<br>City or Tow             | treet and Number or<br>n, State)             | Rural Route Number,  |
| _           | ne Hospita<br>n 24 hours<br>ne Funeral   | Medical Co        | 29a.   | Certifier<br>(Check only (one)  | Certifying Medical                       | Examiner: On the                     | he best of my ke basis of exami                              | nowledge, deat<br>ination and/or ir | h occurred at the ti<br>vestigation, in my                   | ime, date and plac<br>opinion, death occi | e, and due to the ourred at the time, o     | cause(s) and manner<br>date and place, and d | as stated.<br>lue to the cause(s)  |
| _           | To th<br>Within<br>To th   | ğ                 | 29b.   | Signature and t   | itle of certifie                         | er follower                          | ٨  |                                     | 29c. Licens  |   | 2   | 29d. Date signed (Mo                         | 1  |
|             |  |                   | 0.0  |   | typh                                     | lex                                  | mo   | 05 1 5                              |  | 510                                       |   | 03/28  | /10  |
| R           | S 5  |                   |  | 53  | ephe                                     |                                      | 10   | AAn                                 | 1C. 2001   | MEDICAL                                   | PARKWAY                                     | , ANNAPOL                                    | IS, MD 21401   |
|             | Sta<br>Registr   |                   | 31. D  | ate filed (Month  | MAR 3                                    | 0 2010                               | Registrar's Sig  | B. A                                | have   |   |   |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month' つかやり Mary A. Vehrencamp TOVV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🔀 F Months Days Hours Min 214-24-8156 West Virginia ชี918 **Director** May Usual Residence of Decedent 10a, State If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severna Park 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 USA 1301 Holliben Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married hours after White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. aarked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be Page 1 and 2 should be filed ment of Health and Mental Hy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Jackson Stone Martha Jane Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1301 Holliben Road Severna Park, MD 21146 Fred Pritt / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 05, permit. Page 1 a Department of h Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removatirom cemetery, crematory or other place) Bonation 5 Other (Specify) MD Veterans Cemetery Crownsville, MD 2010 22. Norme and Address of Facility Parranco & Sons, P.A. 495 Gov. Ritchie Hwy, Signature of Foneral Service Severna Park Funeral Home Severna Park, MD 21146 203 P. rt 1. Enter the disease or or mpli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List of ly one cause of each line, mmediate cause (Final disease or conditions) Onset and Death Physician/ disease or condition resulting in death) Medical Due to (6) as a consequence of): Examiner MONIA Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 L g ☐ Unknown g Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a, Was an 24b. Were autopsy findings available has prior to completion death?

1 Yes 2 No certificate 2 No 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12/10 Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this in by the funeral 27. Mann of Death Certificate: Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending Investigation
6 Could not be Accident Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practices of To the construction of th (Check ont on 29d. Date signed (Month, Day, Year) Hospital Drive, Glan Burn

State Registrar

DHMH 17 Rev 7/2009

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Amend Item 7 State of Maryland / Department of Health and Mental Hygiene

1 - State WCHD/SH 4/14/10 per FH Certificate of Devi Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 910 2DID Bayard Harper Worth, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day You U.S. 10, 1 🕅 M 2 🗆 F Months Days Hours Min. Mary Land 191-30-4397 **Director** 69 71 Yrs Aug. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 🗆 Yes 2 💢 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20807 Emerald Dr. 21742 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. δ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 🗌 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Painter Crane Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donna Marie Herrmann Worth Bayard Harper Worth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6721 DeBold Rd. Sabillasville, MD 21780 Edward Worth-brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 4-13-2010 | Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Kaitley Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phenna Physicians disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury Examine Due to (or as a consequence of) requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) ed by the a detached f 2 🗆 No 1 Yes 2 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 hnknown Completed is certificate has been si director, page 2 should & schedie Cen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? the Hospital or Attending Physician: The 1 Yes 2 No Yes 2 of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29 c. License number 29d. Date signed (Month, Day, Year) alt mo D18019 APRIL 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAKERSTOWN, MO 21740 DATTA MD BUOMILL ST 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

To the Hospital or Attending Physician: within 24 hours a

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Allins 302 MD Michre en 31. Date filed (Month 32. Redistrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a ptl&IIperPHYS C905 7/1/2010 WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Winner Carole Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UMRMO 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth 9. Bir hplace (State or Foreign Funeral Country) MD Months Hours Min. Oct 4, 1941 1 □ M 2 □ **,** Director 220-40-1581 68 Usual Residence of Decedent or 28a-f show notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 315 Sunset Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Evelyn (Martz) Wolfhope John Wolfhope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Sunset Drive Cumberland MD 21502 John Winner husband 315 Sunset Drive 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
SS Peter & Paul Cemetery 1 Burial 2 Command 3 Removal from State 4/16/2010 Cumberland MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 2017 Ce Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Bilateral Upper extremity deep venous** Approximate Interval Between Bild thrombosis Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oe exham he Medical Examiner Heparin induced Thrombocytopenia Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Pulmonary Embolism, possible 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 performed Yes 2 1 Tyes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo ၉ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28c. Injury at work?

1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatl Funeral Director: the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City of Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Ewithin 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 00 62 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2500 WILLOWBROOK ROAD CLUMBERLAND, MD INI KARTI ATMAMAL IRATUMO 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                 |  |   | For State of Maryland / Dep  1- Stata Registrar Ce   | artment of Health and M<br>rtificate of Death   |  | Jienell I  | 12503  |
|---------------------------------|--|---|--|---|--|--|--|
|                                 |  |   | Decedent's Name (First, Middle, Last)  |   | 2. Date of Dea   | th   | 3. Time of Death   |
|                                 | Physici<br>/Medi   |   | Carl Vito Zello  |   | April  | 10 2010 Year   | 9:45 P <sup>M</sup>  |
|                                 | Examir   |   | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  |  | 4c. County of Death  |  |
|                                 |  |   | Coffman Nursing Home   | Hagerstown  |  | Washington   | County   |
|                                 | Funeral  |   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday   | If Under 1 Year   If Under 24 Hrs.  <br>  Months Days Hours Min.  | 8. Date of Birtl<br>(Month, Day  | 9. Birthpl   | ace (State or Foreign<br>try)  |
|                                 | Director   |   | 217-18-7135  |   | March 1  | 5,1917 Mary  | Land   |
|                                 | land<br>ow   |   | 10a. State 10b. County 10c. City, Town or L  | ocation   |  | 10   | Od. Inside City Limits   |
|                                 | Mary<br>F-f eh   | ţ   | Maryland Washington County Hagersto  | wn  |  |  | 1 □ Yes 2 No   |
|                                 | r 28g  | irec                                      | 10e. Street and Number   | 10f. Zip Code   |  | 10g. Citizen of What Count   | try?   |
|                                 | th wit   | Funeral Director                          | 12306 Walnut Point West  | 21740   |  | U.S.A.   |  |
|                                 | ems<br>er i  | ner                                       | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?   | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto   | cify Yes or No-  | 14. Race - America<br>Black, White, e  |  |
| 36                              | filed within 72 hours after death with the Maryland<br>Hygiene.<br>kther then "naturel", or Items 23a or 28a-f ehow<br>ant, the Medical Examiner must be rodified at   | γF  | 1 Never Married 2 Married 1 Yes, Give 1944 -   | 1 ☐ Yes 2 🔯 No Specify:   |  | Specify: Whi   |  |
| Ö                               | hours<br>lurel   | d by                                      | Year or Dates: 1946  |   |  |  |  |
| 5                               | in 72<br>"na" r  | Completed                                 | (Specify only highest grade completed) (Give   | dent's Usual Occupation<br>kind of work done during most of worki<br>DO NOT use retired)  | ng   | 16b. Kind of Business/Ind  | ustry  |
| 2                               | with<br>iene.<br>ther  | mo  | Elementary/Secondary (0-12)   College (1-4or 5+)   | inist   |  | Aircraft Mfg   | <u>.</u>   |
| 0                               | filed w<br>Hygier<br>other th  | Be C                                      | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name   | (First, Middle,  |  | <b>)</b>   |
| Maryland 21215-0036             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23a or 28a-f ehow any injury or other treumatic event. The Madical Examiner must be notified at ance. | To B                                      | James V. Zello   | Minerva   | M. Kir   | g Zello  |  |
| ary                             | and N<br>ls ma   |   | 19a. Informant's Name/Relationship (Type, Print) 19b. Maii   | ng Address (Street and Number or Rura   | Route Numbe  | r, City or Town, State, Zip  | Code)  |
|                                 | and 2 fealth a mm 27 is  | 1   |  | 6 Walnut Point Wes  | t Hager  | stown, MD 21   | L <b>74</b> 0  |
| Baitimore,                      | of He of Herrican  |   | 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State   | osition (Name of Dimatory or other place)   | ate  | 20c. Location - City or Tox  | wn, State  |
| Ĕ                               | Pages<br>ment of I<br>ent: If its<br>ury or o  |   | Deputies 2 Colemation 3 Chamboat noil State  | wn Mem. Park 4-13-  | 2010   | Ha erstown,  | Maryland   |
| žail                            | permit. Pag<br>Department<br>Importent:<br>any injury o  |   |  | 2. Name and Address of Facility Dou   |  |  |  |
| _                               | OUP # 0  |   |  | 331 Eastern Blvd.   |  |  |  |
|                                 |  |   | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or hear ailure. List only one cause on each line.  | ter the mode of dying, such as cardiac o  | r respiratory arr  |  | Approximate<br>Interval Between<br>Onset and Death   |
|                                 | Physician  |   | Immediate Cause (Final disease or condition resulting in death)  | rake  |  |  | Criser and Death   |
|                                 | /Medical<br>Examiner   |   | Due to (or as a consequence of):   |   |  |  |  |
|                                 |  | <u></u>                                   | Sequentially list conditions, if any, leading to immediate b. Due to (or as a configuence of):   | 1)1011  |  |  |  |
|                                 | ted<br>nsit  | Examiner                                  | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.  |   |  |  |  |
|                                 | al-tra   | Xar                                       | that initiated events resulting in death) Last C. Due to (or as a consequence of):   |   |  |  |  |
| 04/8                            | ficate be executed<br>physician and<br>is the burial-transit   | dicai                                     | d  |   |  |  |  |
|                                 | g phy<br>as th   | 0   |  |   |  |  |  |
| ~                               | death certifi<br>e attending p<br>d for use as   | N/N                                       | IF FEMALE: 23b. Was decedent pregnant in the pest 11 mostle?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 [   | 7e  |  | 23d. Date of deliver   |  |
| 6                               | 0 0 0  | -00                                       |  |   |  |  | у  |
| nox                             |  |   | O Helenaus   | Ectopic pregnancy Other (specify)   |  | Month  | y<br>Day Year  |
| 7.C. BO                         | at the<br>I by the<br>stach  | hysic                                     | 9 ☐ Unknown  | Other (specify)   |  | Month 8  | *  |
| л<br>Э                          | res that the death<br>igned by the atte<br>be detached for   | by Physician/M                            | O I leterane   | Other (specify)   |  | bacco use contribute to the  | Day Year   |
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| ords, P.O                       | aw requires<br>as been sign<br>2 should be   | by  | 9 ☐ Unknown  | Other (specify)nderlying cause given in Part I.   | 1 Ye   | bacco use contribute to the  | Day Year   |
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| Division of Vital Records, P.O. | To the Hospitel or Attending Physicien: The law requires within 24 hours after death.  To the Funerel Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be  | Medical Certification; To Be Completed by | Part II. Other significant conditions contributing to death but not resulting in the understand the significant conditions contributing to death but not resulting in the understand the significant conditions contributing to death but not resulting in the understand the significant conditions contributing to death but not resulting in the understand the significant conditions contributing to death but not resulting in the understand the understand the understand the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not resulting in the understand conditions contributing to death but not result | 26. Place of Death at 3 DOA Other: 4 Jursing Hon f 28c. Injury at Work? M 1 Yes 2 No eet, factory, office 2  vestigation, in my opinion, death occurred 29c. License number | 24a. Was a autops performed to the control of the c | bacco use contribute to the as 2 2 10 0 3 Proba  24b. Were autoportion to come death? 1 Proba  ance 6 Other (Specify, ow injury occurred)  treet and Number or Rural n, State)  ausse(s) and manner as state and place, and due to 9d. Date signed (Month, D. 10 10 10 10 10 10 10 10 10 10 10 10 10   | Pay Year  a cause of death?  a cause of death?  bly 4 Unknown  sy findings available polation of cause of 2 No  Route Number,  ated.  the cause(s)  Pay, Year) |
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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |              | . 10  | aryland         | / Depa                                       | rtment of H   | lealth and N               | /lental Hyg                             | giene           |                                     |                               |  |
|---|--------------|---|-----------------|--|---|----------------------------|---|-----------------|-------------------------------------|-------------------------------|--|
|   |              | State Registrar   |                 | Cer  | tificate of D   | Peath                      |   | Reg. No. 🤈 [    | 110                                 | 12607                         |  |
| Physic  | ian/         | 1. Decedent's Name (First, Middle, Last)  | _               |  |   |                            | <ol><li>Date of Dea<br/>Month</li></ol> | th<br>Qay       | Year                                | 3. Time of Death              |  |
| Med   | ical         | Martha F. Boy   | d               |  |   |                            | 04                                      | 18,             | 2010                                | 4:15 PM                       |  |
| Exam  | ner          | 4a. Facility Name (if not institution, give street and number)  |                 |  | 4b. City, Town, or Location of Death  |                            |   |                 | y of Death                          |                               |  |
| Funera  |              | Union Memorial  5. Social Security Number 6. Sex 7. Aq  | e (In vrs. last | (In yrs. last birthday) If Under 1 Year   If |   |                            | 8. Date of Birtl                        |                 | N/A  9. Birthplace (State or Foreig |                               |  |
| Directo   |              | 212-56-2567 1□M2⊠F  | 59              | Yrs.   | Months Days   | Hours Min.                 | 07/03/                                  | 1950 Maryland   |                                     |                               |  |
| Α.  |              | Usual Residence of Decedent   |                 |  |   |                            | 10.7007                                 |                 |                                     |                               |  |
| yland<br>f sho<br>ed at   | 향            | 10a. State 10b. County  | 10c. City,      | Town or Loc                                  | ation   |                            |   |                 | 1                                   | 0d. Inside City Limits        |  |
| Mar<br>28a-<br>notifi   | Director     | MD N/A  |                 | Ba   | ltimore   | 9                          |   |                 |                                     | 1 XYes 2 □ No                 |  |
| th the<br>3aor<br>ther  |              | 10e. Street and Number  |                 |  | 10f. Zip Code   |                            |   | 10g. Citizen of | What Coun                           | try?                          |  |
| th wi<br>ms 2<br>mus  | Funeral      | 1004 E. Belvedere Ave.  |                 | 110.14                                       |   | 212<br>spanic Origin? (Spe | aif / Van ar Na                         | U.S.A.          |                                     |                               |  |
| or ite  | by Fi        | 11. Marital Status  12. Was Decedent I Armed Forces? 1 Never Married 2 Married 11. Was Decedent I Armed Forces? 1 Yes 2 |                 | ls. V  | Yes, specify Cubar  | n, Mexican, Puerto         | Rican, etc.)                            |                 | ce - America<br>ock, White, e       |                               |  |
| 03(<br>s affe<br>ral",<br>Exar  | l pa         | 3 ☐ Widowed 4 ☐ Woivorced If Yes, Give Year or Dates.   | ,,,,            | 1  | ☐ Yes 2 🎦 No  | Specify:                   |   | Specify         | Blac                                | ·k                            |  |
| 5-0<br>hour   | olet         | 15. Decedent's Education<br>(Specify only highest grade completed)  |                 |  | a. Decedent's Usual Occupation (Give kind of work done during most of working |                            | 16b Kind of B                           |                 |                                     |                               |  |
| Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at  | Completed    | Elementary/Seconday (0-12) College (1-4 or 5  |                 | life. DC                                     | NOT use retired)  | 9                          |   |                 |                                     |                               |  |
| d with  | Be C         | 12th Grade  17. Father's Name (First, Middle, Last)   | []              | Radio  | ology Cl  |                            |   | John I          |                                     | ns                            |  |
| land be filed ental Hy ked oth  | P            | Josh Boyd   |                 |  |   | 18. Mother's Name          |   |                 | ne)                                 |                               |  |
| Marylan 2 should be fil th and Mental 7 is marked of traumatic ev   |              | 19a. Informant's Name/Relationship (Type, Print)  |                 | 10b Mailin                                   | a Addrone (Street a   | Eliza<br>nd Number or Rura | Youn                                    |                 | State Zin C                         | ada)                          |  |
|   |              | Eric Walker(son)  |                 |  |   | edere A                    |   | -               |                                     |                               |  |
| 1 and 1 and of Healt item 2   | 1            | 20a. Method of Disposition  | 20b. Plac       | ce of Dispos                                 | sition (Name of   |                            | Date                                    | 20c. Location   |                                     |                               |  |
| Page 1  |              | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  | Jose<br>And     | eph <sup>cre</sup> E<br>Cren                 | growther #9/<br>latory  | <sup>ት</sup>               | 4/10                                    | Baltir          | nore.                               | MD                            |  |
| Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.  |              | 21. Signature of Funeral Service Licensee   | 11.             | ĴĈ   | Name and Addres   | s of Eacility wn           | Jr. Fu                                  | neral           | Home                                |                               |  |
|   |              | Retuch N. Wil   | llan            | no[21]                                       | 40 N. F   | ulton A                    | ve.,Ba                                  | ltimoı          | ce,MD                               | 21217                         |  |
|   |              | 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line  |                 | Approximate Interval Between                 |   |                            |   |                 |                                     |                               |  |
| Physician<br>Medica   |              | Immediate Cause (Final disease or condition resulting in death) a. Pusts (see   | (C E)           | an of  | alopath   |                            |   |                 |                                     | Onset and Death               |  |
| Examine   |              | Due to (or as a   | a consequer     | nce of): \                                   | 4   | A                          |   |                 |                                     | 2 - 1                         |  |
|   | ē            | Gequentially list conditions, if any, leading to immediate cause. Enter Underlying                                      | a consequer     | nce of):                                     | Kenax (   | XILEGO.                    |   |                 | - 1                                 | 5 mouthe                      |  |
| uted<br>d<br>ansit  | Examiner     | cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.   | otie            | 2  | un Roche  | + Serge                    | coul                                    | Dun O           | rath ?                              | - 1 year                      |  |
| exect<br>an an<br>rial-tr   | <u>~</u>     | resulting in death) Last Due to (or as a  | a consequer     | nce of):                                     | 1 0.1   |                            |   | 7               | 17                                  |                               |  |
| 60<br>ate be<br>rhysici   | dical        | d. Lest   | De C            | octo   | ouzeli  | his .                      |   |                 |                                     | - 4 mouths                    |  |
| 687<br>certifica<br>ding pl   | ₩            | IF FEMALE:  | 7               |  | 9   |                            |   |                 |                                     |                               |  |
| Box 6 death ce he attend led for us   | ian          | III trie past 12 iligritis?   | 2 - Fetal d     | death 3 🗌                                    | Ectopic pregnancy   | y                          |   |                 | ate of delive<br>onth               | ry<br>Day Year                |  |
| . <b>bC</b><br>ne deg<br>/ the a  | Physician/Me | 1 ☐ Yes 2 No 4 ☐ Pregnant a g ☐ Unknown   | t time of dea   | atn 5∟                                       | Other (specify)   |                            |   |                 |                                     | July                          |  |
| that the ned by a detact  | by Pt        | Part II. Other significant conditions contributing to death b   | ut not result   | ing in the ur                                | nderlying cause give  | en in Part I.              | 23e. Did to                             | bacco use con   | tribute to th                       | e cause of death?             |  |
| uires nu sign   | ed b         |   |                 |  |   |                            | 1 □ Y                                   | es 2 No         | 3 Prob                              | ably 4 Unknown                |  |
| w req   | Completed    |   |                 |  |   |                            | 24a. Was a                              |                 |                                     | sy findings available         |  |
| VITAI KECOTGS, ysician: The law requires is certificate has been sig  | E O          |   |                 |  |   |                            | autop<br>perfor<br>1 \sum Yes           | med?<br>2 ເX No | death?                              |                               |  |
| ian:  | Be           | 25. Was case referred to medical examiner?  |                 |  | 26. Pla   | ce of Death (Check         |   |                 |                                     |                               |  |
| hysic<br>his ce   | 은            | 1 ☐ Yes 2 🔼 No Hospital:  | ent 2 EF        |  | Othe  | r:<br>4  Nursing Ho        | me 5 🗆 Reside                           | ence 6 🗆 Oth    | ner (Specify)                       |                               |  |
| Ing P   | Certificate: | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of inju   |                 | Bb. Time of injury                           | 28c. Injury<br>work?  | ?                          | 28d. Describe ho                        | ow injury occur | red                                 |                               |  |
| ttend<br>death<br>death<br>stor: /  | ti[          | 2 Accident Investigation 3 Suicide 6 Could not be   | un . At home    | a form atra                                  |   | Yes 2 □ No                 | 001                                     |                 |                                     | Double Mireshou               |  |
| DIVISION OF tal or Attending Ph rs after death. al Director: After th ed in by the funeral  |              | 4 Homicide determined building, etc   |                 | e, ram, sue                                  | et, lactory, office   | l.                         | 28f. Location (St<br>City or Town       |                 | er or nurar                         | noute Number,                 |  |
| Division of Vital Records, P.O. Box 68/60  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit   | Medical      | 29a. Certifier 1 Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of e                      | my knowled      | lge, death o                                 | ccured at the time,   | date and place, an         | d due to the cau                        | se(s) and mann  | ner as stated                       | d.<br>se(s) and manner stated |  |
| the Fithin 24 the Fithin 1 | Me           | only one) 3 Certifying Nurse Practioner: To the   |                 |  |   | time, date and plac        | e, and due to the                       |                 | nanner as sta                       | ited.                         |  |
| <b>₽ ₽ ₽ ₽</b>  |              | 1 Joseph HD   |                 |  | AT 2  | 243 891                    | 16. Bu                                  | 041             | 18/20                               | *                             |  |
|   |              | 30. Name and address of person who completed cause of d   | eath (Item 2    | 3a) (Type, Pr                                | I Hospil  | d 2012                     | ull feet                                | iousity         | Parkle                              | ياهم                          |  |
| Sta   | ate.         | 31. Date filed (Month, Day, Year) 32 Registra   | ar's Signatur   |  | 100   |                            | Ballin                                  | me Mi           | 2121                                | U. X                          |  |
| Regist  |              | APR 2 3 2010 Cerus  | 1               | he   | Red   |                            |   |                 |                                     |                               |  |
|   |              |   |                 | 7.4  |   |                            |   |                 |                                     |                               |  |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy M. Bohn April 20<sup>ay</sup> 2010<sup>a</sup> 6:30P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Summerville Assisted Living Westminster Carroll 5. Social Security Number 6. Sex Age (In yrs. last birthday)
92 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-01-8587 1 M 2 🔀 Hours Min. (Month, Day Country) Director Usual Residence of Decedent 23a or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Carroll Westminster 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Washington Rd. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 H Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles L. Pittinger Minnie A. Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah B. Hossler-daughter 300 Snowfall Way, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow Branch Cem 4-23-2010Westminster, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Fletcher Funeral acmas Z E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DIAN Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Yes the Funeral Director: After this certificate has been s mpleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) assisted Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specific 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 (Check only one) within To the 29c. License number 29d. Date sined (Month. Day, Year,

State Registrar

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10b-c, per Fh g902 4/23/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2:00 AM Bieber 2010 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner nivercito mo If Under Year if Under 24 Hrs. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2 58 Director 212-56-3004 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner in ast he notified at 10b. Count Harford 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Director Abingdon 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 3614 Longridge Ct 21009 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ş Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Pearl Wiseman Franklin Benjamin Fuller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra William R. Bieber / Husband 3614 Longridge Ct., Abingdon, Maryland 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gdn 4-23-10 Baltimore, Maryland of Funer 9 ervice Lice 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiac "hysician annuthmia 0 disease or condition resulting in death) minutes Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ower Exthemi 2 No 3 Probably 4 Unknown 1 ☐ Yes , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No Division of Vital 1 ☐ Yes 2 **N**0 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ieral Director After this filled in by the funeral dir Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation within 24 hours a er deat To the Funeral Director 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 29c. License number M.D 30. Name and address of person who completed cause weath (Item 23a) (Type, Print) Shin 511 Beltimore 10-10 31. Date filed (Month, Day, 3. Registrar's Signature Year State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amend 20-22 per f.h g902 492371169 ten OF Death Reg. No. 2 Date of Death **Physician** 12:35 2010 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Û a Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 V F Months Days Hours Min. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Exprised constitution. Was 1 ☐ Yes 2 No Director Hugerstown MINATOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with · Hygiene. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? / 1 ☐ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 TNo Specify. þ Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nfan 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be helsea Lynn ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) -MOTHER ennsulvania Hagerstown MID 21740 131 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/10 Bayview Crematory Baltimore,Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert J. Godack, Jr. (per DVR) Kaczorowski F.H., 1201 Dundalk Ave. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final extreme **Physician** 1 MINS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an has autopsy performed?

1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) astern Bartimore, MD 21224

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 23

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 20-22 per f.h. g902 463/ili0ate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year Physician Brooks 12:37 2010 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS Fri Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🗗 F Months Hours Min. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, If a Medical Exprints must be notified at 1 □Yes 2 No Director YWO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USH Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 14 Bace - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nfan permit. Pages 1 and 2 should be filed I Department of Health and Merital Hygic Important: If item 27 is marked other I any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother 13127 Pennsylvania Hagerstown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **Bayview Crematory** 2/20/10 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Robert J. Godack, Jr. (perDVR) Kaczorowski F.H. 1201 Dundalk Ave 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 11 Mins disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or se a consequence of) Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 No 2 No 1 ☐ Yes 1 ☐ Yes After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, within 24 hours arter co...

To the Funeral Director: Aff

To the Funeral Director: Aff

> State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 1211

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

|                            |  |                  | For<br>State   | State o                                      | f Marylan  | -                              | artmen<br><i>tificate</i>                |                     |                       | and Me        | ental Hy                     |              | 201                                     |               | 12                        | 612            |
|----------------------------|--|------------------|--|--|--|--------------------------------|--|---------------------|-----------------------|---------------|------------------------------|--------------|---|---------------|---------------------------|----------------|
|                            |  |                  | Registrar  1. Decedent's Name (First, Middle,                            | Last)  |  | 007                            | inoate                                   | , 01 1              | Catri                 |               | 2. Date of De                | Reg. N       | lo.                                     | 1             | 3. Time of                | Death .        |
|                            | Physicia   |                  | Helen  |  | yd   |                                |  |                     |                       |               | Month<br>April               |              | ay 2010                                 | ar I          | 5:10                      | P M            |
|                            | Medic<br>Examin  |                  | 4a. Facility Name (if not institution,                                   |  |  |                                | 4b. City,                                | Town, or            | Location of           |               | PLIT                         |              | c. County of D                          |               | 7.10                      |                |
|                            | 1  |                  | 9634 Culver S  | treet  |  |                                |  | Ken                 | singt                 | on            |                              |              | Montg                                   | omer          | y                         |                |
|                            | Funeral  |                  |  | 6. Sex                                       | 7. Age (In yrs. la                               | •                              | If Under<br>Months                       |                     | If Under<br>Hours     | 24 Hrs. 8     | Month Da                     | th<br>Vear   | 9.                                      | Birthplace    | e (State o                | r Foreign      |
|                            | Director   |                  | 578-32-3314  | 1 □ M 2 🌠 F                                  | 94   | Yrs.                           | Working                                  | Days                | 110013                | F             | ebruary                      | 7'24,        | 1916 Was                                | shingt        | ton, D                    | ).C.           |
|                            | and<br>show  | <u>_</u>         | Usual Residence of Decedent  10a. State 10b. County                      | ·  | 10c. City  | , Town or Lo                   | cation                                   |                     |                       |               |                              |              |   | 10d.          | Inside Cit                | tv Limits      |
|                            | Marylar<br>28a-f sl<br>otified   | ectc             | Maryland Mont  | gomery                                       |  | Kensin                         |  |                     |                       |               |                              |              |   | - 1           | 1  Yes                    |                |
|                            | he M<br>or 28<br>e not   | ğ                | 10e. Street and Number   | Бошегу                                       |  | Kensti                         | 10f, Zip                                 | Code                |                       |               |                              | 10a. C       | Citizen of What                         |               |                           |                |
|                            | with i   | eral             | 9634 Culver S  | treet  |  |                                |  | 20                  | 0895                  |               |                              | Uni          | ted St                                  | ates          |                           |                |
|                            | be filed within 72 hours after death with the Maryland antal Hyglene.<br>Ked other than "natural", or items 23a or 28a-f sho<br>c event, the Medical Examiner must be notified at  | Funeral Director | 11, Marital Status   |  | dent Ever in U.S                                 | i. 13. V                       | Vas Deced                                | ent of His          | spanic Ori            | gin? (Specif  | y Yes or No-                 |              | 14. Race - A                            | merican l     | ndian,                    |                |
| 98                         | fter d<br>", or i<br>amin  | ۾                | 1 Never Married 2 Marri  | ed 1 Yes<br>If Yes, Give                     | 2 X No   | - 1                            | Yes 2                                    |                     |                       |               | can, etc.)                   |              | Black, W                                |               |                           |                |
| Ö                          | 2 hours aft<br>"natural",<br>dical Exa   | Completed        | 3 X Widowed 4 Divorced   | Year or Da                                   | ites.  |                                |  |                     |                       |               |                              |              | Specify: W                              | hite          |                           |                |
| <del>1</del> 5             | 72 ho<br>n "na<br>fedic  | ם                | 15. Deceden<br>(Specify only highes                                      |  |  | 16a. Deced                     | lent's Usua<br>kind of wori<br>O NOT use | k done di           | ition<br>uring mosi   | t of working  |                              | 16b.         | Kind of Busine                          | ss Indust     | ry                        |                |
| 12                         | ithin<br>ene.<br>r thai  | 5                | Elementary/Seconday (0-12)   | College (1-                                  | -4 or 5+)  |                                | ountar                                   | -                   | vamin                 | or            |                              | Fo           | deral (                                 | Corror        | rnmor                     | . +            |
| 9                          | iled within<br>I Hygiene.<br>other tha<br>ent, the N   | வ                | 17. Father's Name (First, Middle, La                                     | est)   |  | ACCC                           | uncai                                    | 16 11               |                       |               | First, Middle,               |              |   | GOVE1         | rumer                     | IL.            |
| <u>a</u>                   | be fil<br>ental<br>rked<br>ic ev   | 잍                | Charles L. Hei   | nrich  |  |                                |  |                     | Ann                   | ,             | ogswe                        |              | ,                                       |               |                           |                |
| Maryland 21215-0036        | ge 1 and 2 should be file<br>thof Health and Mental H<br>If item 27 is marked or<br>or other traumatic ever  |                  | 19a. Informant's Name/Relationsh   | ip (Type, Print)                             |  | 19b. Mailin                    | g Address                                | (Street a           | nd Numbe              | er or Rural F | Route Numbe                  | er, City o   | or Town, State,                         | Zip Code      | <b>∍</b> )                |                |
|                            | d 2 sl<br>alth a<br>r 27 i   |                  | William C. Boyd  | / Son  |  | 114 B                          | Beaver                                   | Dar                 | n Rea                 | ch, R         | ehobo                        | th B         | Beach, I                                | Delav         | ware                      | 19971          |
| J.e.                       | of He<br>fiter   |                  | 20a. Method of Disposition   | o□p  |  | lace of Dispo<br>emetery, cren | sition (Nam                              | e of                | a) [                  | April         | 23,                          | 20c.         | Location - City                         | or Town,      | State                     |                |
| <u><u>E</u></u>            | Page<br>nent<br>ant: I   |                  | 1 🖄 Burial 2 □ Cremation<br>4 □ Donation 5 □ Other (S <sub>i</sub>       |  | Park Park  | lawn Me                        | morial                                   | Park                |                       | 2010          | ) 23,                        | Ro           | ckville                                 | , Ma          | ryla                      | nd             |
| Baltimore,                 | permit. Page 1 and 2 sh<br>Department of Health ar<br>Important: If item 27 is<br>any Injury or other trau   |                  | 21. Signature of Fundral Service Li                                      | ¥/   | M013   | 0.5 Rol                        | Name and<br>bert A                       | Addres              | s of Facilit<br>phrey | Funera        | 1 Home/                      | Beth<br>Mary | nesda-Che<br>vland 208                  | vy Ch         | ase,                      | Inc.           |
|                            |  |                  | 23a. Part F. Enter the disease, or shock, or heart failure. List or      |  |  |                                |  |                     |                       |               |                              |              | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Ap            | proximate                 |                |
| , J                        | Physician/   |                  | Immediate Cause (Final disease or condition                              |  | trointe:   | stinal                         | B1e                                      | ьd                  |                       |               |                              |              |   |               | erval Betv<br>set and D   |                |
|                            | Medical  |                  | resulting in death)  | a  | or as a consequ                                  |                                | 510                                      |                     |                       |               |                              |              |   |               |                           |                |
|                            | Examiner   | Ļ                | Sequentially list conditions,  | b. ———                                       |  |                                |  |                     |                       |               |                              |              |   |               |                           |                |
|                            | p t  | nie              | if any, leading to immediate cause. Enter Underlying                     | Due to (                                     | or as a consequ                                  | ence of):                      |  |                     |                       |               |                              |              |   |               |                           |                |
| EAN                        | and<br>trans   | xal              | Cause (Disease or iinjury that initiated events resulting in death) Last | c. Due to (                                  | or as a consequ                                  | ence of:                       |  |                     |                       |               |                              |              |   | -             |                           |                |
| •                          | ate be executed<br>bhysician and<br>the burial-transit   | dical Examiner   | rocaling in acast, Eac.  |  |  |                                |  |                     |                       |               |                              |              |   |               |                           |                |
| 760                        | phys<br>phys   | g                |  | d  |  |                                |  |                     |                       |               |                              |              |   |               |                           |                |
| P.O. Box 687               | certifi<br>nding<br>use as   |                  | IF FEMALE:<br>23b. Was decedent pregnant                                 | 23c. If yes, outo                            | come of pregnar                                  | ncy                            |  |                     |                       |               |                              |              | 23d, Date of                            | delivery      |                           |                |
| XO                         | eath<br>atter  | icia             | in the past 12 months? 1 ☐ Yes 2 🖸 No                                    | 4 Pregr                                      | Birth 2 🗀 Fetal<br>nant at time of d             |                                | Ectopic p Other (sp                      |                     | 4                     |               |                              |              | Month                                   | Day           | y Y                       | 'ear           |
| Э. Е                       | the d  | hys              | 9 🗌 Unknown  | g □ Unkn                                     | own  |                                |  |                     |                       |               |                              |              |   |               |                           |                |
| Α.                         | that<br>med k  |                  | Part II. Other significant condition                                     | ns contributing to de                        | eath but not resu                                | ulting in the u                | nderlying c                              | ause give           | en in Part I          | l.            | 23e. Did t                   | obacco       | use contribute                          | to the ca     | ause of de                | eath?          |
| 5,                         | quires<br>en sig<br>uld b  | pa               |  |  |  |                                |  |                     |                       |               | 1 🗆                          | Yes 2        | 2 🗓 No 3 🗆                              | Probably      | y 4□t                     | Jnknown        |
| Ö                          | iw rec<br>as bec<br>2 sho  | Completed by     |  |  |  |                                |  |                     |                       |               | 24a. Was<br>auto             |              | 24b. Were                               | autopsy f     | findings a<br>etion of ca | vailable       |
| 36                         | The la   | ĕ                |  |  |  |                                |  |                     |                       |               | perfo                        | ormed?       | death                                   | i?<br>Yes 2 🗆 | _                         |                |
| <u></u>                    | ian: ]<br>ertifica<br>ctor, p  | Be               | 25. Was case referred to medical examiner?                               |  |  |                                |  | 26. Pla             | ce of Deat            | th (Check o   |                              |              |   |               |                           |                |
| ₹                          | hysio<br>his ce<br>I dire  | 유                | 1 🗌 Yes 2 🔀 No   |  | Inpatient 2 🗆 I                                  |                                |  | Othe                | r:<br>_4 □ Nu         | ursing Home   | 5 🔀 Resi                     | dence        | 6 Other (Sp                             | ecify)        |                           |                |
| of                         | ing P  | ate              | 27. Manner of Death  1   Matural  5 □ Pending                            | 28a. Date of (Montal                         | of injury<br>h, Day, Year)                       | 28b. Time of<br>injury         | 28                                       | 3c. Injury<br>work? | >                     |               | d. Describe l                | now inju     | iry occurred                            |               |                           |                |
| <u>.</u> 0                 | tendi<br>leath<br>tor: A<br>the fu   | <u>ë</u>         | 2 Accident Investig 3 Suicide 6 Could n                                  | ation  |  |                                | М  |                     | Yes 2 🗌               |               |                              | _            |   |               |                           |                |
| Division of Vital Records, | To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pl completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director. | Certificate:     | 4 Homicide determine   | 28e. Place                                   | of Injury - At hor<br>ng, etc. (Spec <i>ify)</i> | me, farm, stre                 | eet, factory,                            | office              |                       | 28            | f. Location (<br>City or Tov |              | nd Number or i<br>e)                    | Rural Rou     | ite Numbe                 | ər,            |
| _                          | lospit<br>t hour:<br>unera<br>ed fille   | Medical          | 29a. Certifier 1 X Certifying (Check 2 Medical Ex                        | Physician: To the be<br>caminer: On the basi | est of my knowle                                 | edge, death o                  | occured at t                             | the time,           | date and              | place, and o  | due to the ca                | iuse(s) a    | and manner as                           | stated.       | s) and mar                | ner stated     |
|                            | the H<br>hin 24<br>the F<br>nplete   | Me               | only one) 3 Certifying   | Nurse Practioner: T                          |  |                                | leath occur                              | red at the          | time, date            |               |                              | e cause      | e(s) and manner                         | as stated.    |                           | iiroi stateti. |
|                            | Vit<br>To<br>COD   |                  | 29b. Signature and title of certifier                                    |  |  |                                | 29c.                                     | License             |                       |               |                              |              | ate signed (Mo                          |               |                           |                |
|                            |  |                  | 1/6  |  |  |                                |  | שטע                 | 1983                  |               |                              | Apr          | il 21,                                  | 2010          | ,                         |                |
|                            | 14   |                  | 30. Name and address of person w Kashif Firozvi                          |  | e of death (Item<br>101 Med :                    | , , , , .                      | ,  | nivo                | #21                   | nn s-         | Hvar                         | Snr          | ina Ma                                  | rv1a          | nd ?                      | 0902           |
|                            | Sta  |                  | 31. Date filed (Month, Day, Year)  |  | egistrar's Signati                               |                                | ark D                                    | TIVE                | , 112                 | 3.            | TTAGT                        | SPL.         | riig, iia                               | тута          | .114 2                    |                |
|                            | Sta  | .e               | ADD 9 3 2010   | 6  | A  | 1                              |  |                     |                       |               |                              |              |   |               |                           |                |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene me, g902,04/22/2010dhb Reg. No. 1 - For State Registrar 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year Physician ONOVER 10 2010 /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BaltiMore ed \_ If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 1 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 188-28-7885 **Director** 16 36 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 🏋 ☐ No Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be none. 7700 York Road Room 205 A 21286 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 5+yrs Mental Health Therapist <u> Health Clinics</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be rent of Health and Mental Joseph Conover Ophelia Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Conover-Wife 1643 North Payson Street, Baltimore, Md 21217 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 4/16/2010 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician Due to (r as a consequence of):  $\alpha$ Month /Medical Examiner Due to (or is a consequence of): Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATIONAPPROVED BY MEDICAL EXAMINER Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence physician a Physician/Medical OK attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No ed by the a 0 9☐Unknown 9 ☐ Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? certificate nouse 1□ Yes 2□ No OH Division or Vital the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours aren were the Funeral Director: After this wantetely filled in by the funeral directors. P 28d. Describe how injury occurred Space heater ignited carpet 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury Certification: 6:15 natural 2 Accident 5 Pending investigation 02/13/2008 **a** M 1 ☐ Yes 2 X No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6225 York Road Baltimore, MD 4 ☐ Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State

30. Name and address of person who

Registrar

DHMH 17 Rev 1/2001

VORX Rd

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, b, perFH, G904, 6/17/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dolores Keith Cohen Month 2010 Year 3:50 P M April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hosptial Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Nov. 14, 1918 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Min. Pennsylvania 91 Director Yrs Nov. 173-10-8673 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗆 Yes 2 🖾 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8817 Altimont Lane 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates. 1943-44 Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Community Health Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Crutchfield Keith Bertha Meintal 19**Lewrs**t's**Ker-Ph**ti**con** (Me, Print) David K. Cohen / Son Hing Address Street and Number of Rural Route Number City and own State Zip Code)

Research Chew Chase 12996 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Uniformed Services 4/22/2010 Bethesda, MD Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Mceps de 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death days shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Respiratory Failure Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis days Sequentially list conditions, if any, leading to immediate Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Multiorgan Failure **d**ays Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregna 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 1 Yes 2 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Ceftifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D21891 Ox, 30. Name and address of person who completed cause of death (Item 23a) (Type, BLAIR M.D 7525 GREENWAY CENTER : GREENBELT MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-02993 State of Maryland / Department of Health and Mental Hygiene **Donald Chestnut** 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 17, 2010 0250 hrs Medical Examiner Don Curtis Chestnut 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Cecil Elkton Union Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Country) FL Months Days Hours 09/27/1967 591-18-5364 Director 42 1X M 2 F Vrs Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10b. Count Y OF MD Cecil Elkton 1 Yes 2 X No or 28a-f show 23a or 28a-f show hours after death with the Maryland Director 10a, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 USA 205 W. Pulaski Hwy. 37 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after death wirent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items the Medical Examiner must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 X Yes White 4 Divorced If Yes, Give Year 1990-2010 1 Yes 2XX No specify: Specify: 3 Widowed Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) U.S. Military Sergeant 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Rhodes it: If item 27 is marked other traumatic event, I Don Chestnut 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Victoria Chestnut / Wife 8266 Fenton Lane, Pasadena, MD 21122 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, w. Arundel Crematory 1 Burial 2 X Cremation 3 Removal from State 04/24/2010 Important: 1 Odenton, MD Donation 5 Other Specify: 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA 21. Signature of Funeral Service Licensee M01452 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiomegaly with biventricular hypertrophy & Approximate Interval **Physician** Between Onset and /Medical Death right ventricular dilatation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate Dire to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit Physician/Medical X UNPENDED #MI, 23a, 27, per ME G903 5/13/10 TT 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed 2 No ✓ Yes 2 No 1 🗸 Yes director, page 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other After this No 1 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death 1 X Natural 1 Yes 2 No Pending Director: the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc n 24 hours after o 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the within 2 To the 1 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 17, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

10-03038

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Bernice Cephas State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 18, 2010 Medical Examiner Cephas 1708 hrs Bernice 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 826 West North Avenue Apt.2B **Baltimore City** 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country) MD Days Hours 09-24-50 Director 59 215-58-1330 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a State 10c City Town or Location 1 Yes 2X X No Randallstown Baltimore with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3420 Barry Paul Road Apt.#204 21133 Funeral 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or Nodeath v Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after on near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", on or other traumatic event, the Medical Examiner in Specify: American 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 2 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12th Grade Domestic 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Smith, Sarah Simms Homer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 3420 Barry Paul Road Apt.#204 Randallstown Yolanda Hope-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 05-01-10 Catonsville, MD Department of Important: 1 injury or oth Metro Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21 Signature of Funeral Service Licenses Wylie Funeral Home MD 2121 N. Gilmor Street Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and Mudien a. Narcotic (morphine) intoxication Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a X UNPENDED AMENDED 23a, 27, 28a-f, perm, E g902 4/27/10 TT Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day signed by the attending be detached for use as t 1 Live birth Fetal death 3 | Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed of Vital Records, this certificate has been s director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ✓ Yes 2 No death? 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 2 No ၉ 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 No Director: Fd 4/18/10 Fd 4:45 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 826 W. North Ave Apt 2B Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be within 24 hours a To the Funeral 1 house determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 19, 2010

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

State

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

2. Registrar's Signature

Ana Rubio MD.

111 Penn Street, Baltimore, MD 21201

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eva Voneita Contino April 2010 9:30pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7514 Norwood Avenue Sykesville Carroll 8. Date of Birth (Month, Day, Feb. 21 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign New Mampshire **Funeral** Months Days Hours Min 216-36-3774 Director 70 Yrs. Usual Residence of Decedent 23a or 28a-f shov 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits MD Carrol1 Sykesville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 7514 Norwood Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 X No Black, White, etc. ō δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Clerical injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Olen Gear Rella Cutright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Kelly C. Crum (Daughter) 7514 Norwood Avenue, Sykesville, MD 21784 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State All County Cremation 4/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licenses AATGHT FUNERAL HOME & CHAPEL, 400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 14 Immediate Cause (Final Physician/ CUNG CAUCKA neen 177 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): physician and s the burlal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Les 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes Other: 2 1 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this filled in by the

City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 228792

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JA-COBY

WESTMINSTER NO #130 826 21157 WASHINGTON

State Registrar

Medical

How mes

31. Date filed (Month, Day, Year) 32. Registral's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |               | 1-For State Constraint of Department of Treatment of Prealtman Certificate of Death  | nd Mentan           | ,,                               | 2010<br>g. No.                 | 2618   |
|--|---------------|--|---------------------|----------------------------------|--------------------------------|--|
| Physici  |               | 1. Decedent's Name (First, Middle,Last)  |                     | 2. Date of Death                 | 1                              | 3. Time of Death                                   |
| edical Exam  | iner          | ALEX CRAIN  4a. Facility Name (if not institution, give street and number)  4b. City, Town, and the control of  | or Location of Dea  | Month<br>April 19, 20            | 4c. County of Death            | 1742 hrs   |
|  |               | 1623 Lancaster Street Baltimore  |                     | ш                                | N/A                            | ,  |
| Funeral  |               | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye  |                     |                                  | h (MM/OD/YYYY) 9. Bir          | thplace (State or Foreign                          |
| Director   |               | 215-72-4121 1XM 2 F 47 Yrs.  | ays Hours Mi        | <sup>n.</sup> 11/05/             |                                | LLINOIS  |
| any  |               | Usual Residence of Decedent  10a. State  |                     | _                                |                                | 10d. Inside City Limits                            |
|  | Ä             | MD N/A BALTIMORE   |                     |                                  |                                | 1 X Yes 2 No                                       |
| Maryla<br>28a-f<br>d at or   | Director      | 10e. Street and Number 10f. Zip Code   |                     | 10                               | g. Citizen of What Cou         | ntry?  |
| th the Maryland<br>23a or 28a-f show s<br>notified at once.  |               |  | 1231                |                                  | U.S.A                          |  |
| 5-0036<br>ed within 72 hours after death with the Maryland<br>tygiene.<br>other than "natural", or items 23a or 28a-f sho<br>the Medical Examiner must be notified at once.  | Funeral       | 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Married 4 Never Married 4 Married 5 Married 6 Married 7 Married 7 Married 8 Married 9 Married   |                     |                                  | 14. Race - Amen<br>White, etc. | can Indian, Black,                                 |
| fter de<br>I", or  |               | 1 Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No   | No specify:         |                                  | Specify: WI                    | HITE   |
| nours a<br>natura<br>Xamit   | ed by         | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occup during most of working [if  |                     |                                  | 16b. Kind of Business/         | ndustry  |
| 36<br>in 72 l<br>han "1  | plet          | Elementary/Secondary (0-12) College (1-4 or 5+)  |                     | in out                           | COMP                           | IMED   |
| 215-0036<br>be filed within 72<br>atal Hygiene.<br>rked other than 'ent, the Medical   | Completed     | 17. Father's Name (First, Middle, Last)  |                     | ne (First, Middle, M             |                                | JIEK   |
| 21<br>Se fill<br>stal I  | Be            | ROBERT CRAIN   | BARBAR              |                                  | RMONT                          |  |
| D 21<br>should band Mer<br>7 is mar  | To            | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Str.  HUNTER CRAIN / SON  5617 GOVAN  |                     |                                  |                                |  |
| imore, MD 2  Pages 1 and 2 shoument of Health and N  tant: If item 27 is r   |               | 20a. Method of Disposition 20b. Place of Disposition (Name of c  |                     | Date Date                        | MORE, MD.                      | 21212<br>Town, State                               |
| Baltimore, permit. Pages la Department of He Important: If ite injury or other to  |               | 1 Burial 2 XCremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: BAYVIEW CREMA   | mony 4/             | 22/10                            | DATEMODI                       |  |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or ott  |               | 4 Donation 5 Other Specify: BAYVIEW CREMA 21 Sprature of Funeral Specylciansee 22 Name and Addre   | ss of Facility      | ZZ/10                            | BALTIMORE                      | E, MARYLANI  |
|  | _             | molin Jacob Toot Ex  | sternca             | venue, b                         | UNERAL HOSALTIMORE,            | MD 21231   |
| Physician<br>/Medical  |               | failure. List only one cause on each line.   | g, such as cardiac  | or respiratory arres             | st, shock, or heart            | Approximate Interval<br>Between Onset and<br>Death |
| Examiner   |               | Immediate Cause (Final disease or condition resulting in death)  a. Asphyxia by hanging  Due to (or as a consequence of):  |                     |                                  |                                | Death  |
|  | L             | Sequentially list conditions, b  |                     |                                  |                                |  |
|  | Examine       | if any, leading to immediate cause. Enter Underlying Cause.  |                     |                                  |                                |  |
| B. B.  | Exan          | events resulting in death) Last Due to (or as a consequence of):   |                     |                                  |                                |  |
| 760, Cate be executed physician and the burnal - transit   |               | d. UNPENDED AMENDED  |                     |                                  |                                |  |
| '60,<br>rate be<br>chysici<br>he buri  |               | IF FEMALE: 23c. If yes, outcome of pregnancy   |                     |                                  | 23d. Date of delivery          |  |
| 687<br>certific<br>nding p   | ician/        | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3  | Ectopic pregn       | ancy                             | Month D                        | eay Year   |
| Box 687( ne death certifica the attending ple hed for use as the   | Physic        | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown   |                     |                                  |                                |  |
| P.O. les that the igned by to detache  | by Pr         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause  | given in Part I.    | 1                                | acco use contribute to         |  |
| S, P<br>quires t<br>an sign  | led t         |  | <del></del>         |                                  | 2 No 3 Prob                    |  |
| cord<br>law rec<br>has be  | Completed     | -  |                     | 24a. Was ar<br>autops<br>perform | y prior to c                   | topsy findings available<br>ompletion of cause of  |
| Re(<br>: The<br>ificate<br>r, page   |               | 25. Was case referred to medical 26.Plac   |                     | 1Yes 2                           |                                | s 2 No   |
| /ital /sician sis cert directo   | o Be          | examiner?  1  Yes 2  No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA   | Other Nursi         |                                  | tesidence 6 🗸 Other            | : Scene  |
| Division of Vital Records, P.C ral or Attending Physician: The law requires that its after death.  **I Director: After this certificate has been signed led in by the funeral director, page 2 should be deat.   | -1            | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Inj   | jury at Work?       | 28d. Describe ho                 | ow injury occurred             |  |
| sion<br>ttendi<br>death.<br>ctor: ,  | atio          | 2 Accident Investigation Apr 19, 2010 1730 hrs   | Yes 2 V No          | Subject hang                     |                                |  |
| Divis<br>al or A<br>s after<br>al Direct   | ertification: | 3 Suicide 6 Could not be determined (Specify) Townbouse / Powbouse   | building, etc.      | or Town, Sta                     | reet and Number or Ru          |  |
| Hospit:<br>4 hour<br>7 uners   | 0             | 4 Homicide (Specify) Townhouse / Rowhouse  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, of the configuration of the configurat | date and place, and | ·                                | Street, Baltimore , I          |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the buring. | Medical       | one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinio and manner stated.  |                     |                                  |                                |  |
| F * F 3  | M             | 29b. Signature and title of certifier 29c. Licen   | nse number          | 29d. Date signed (Mor            | th, Day, Year)                 |  |
| ,  |               | (all lall)   | .M.E.               |                                  | April 20, 2010                 |  |
| 3  |               | 30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Bal  | Itimore, MD 21      | 1201                             |                                |  |
|  | ate           | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |                     |                                  |                                |  |
| Regist   | rar           | ADD 2.3 2010 /2 / / / / /  |                     |                                  |                                |  |

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2<u>010</u> Month April Physician/ 3:00a <sup>™</sup> Cherry Patricia Ann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Aberdeen 808 Randolph Drive 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Funeral Oct. 21, 1934 Hours Min 1 □ M 2 🛣 F Pennsylvania 75 Director 213-30-6232 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Harford Aberdeen Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 808 Randolph Drive 21001 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 2 X No Maryland 21215-0036 Specify: White 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates and 2 should be filed within 72 hour Flealth and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Housewife In home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ Margaret Walsh <u>William John Lindes</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 808 Randolph Dr., Aberdeen, MD 21001 Robert E. Cherry (husband) or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ott 1 Durial 2 Cremation 3 Removal from State Ferris & Company 4/23/2010 | West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee ustendine Aberdeen, 23a. Part 1. Enter the disease, or comblications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner quentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical The law requires that the death certificate be for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Hypertension, Secondar 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 performed, 1 Yes 2 No this certificate Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident 3 ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Suite 203

Haure De brace

Pulas

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Davis 9:03 AM Eunice Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Court Baltimore Rosanda Baltimore city 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. North Carolina Director 23a or 28a-f show 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Examiner must be notified 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married permit. Page 1 and 2 should be filed within 72 hours after þ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates item 27 is marked other than "natural", other traumatic event, the Medical Exa 3 X Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. omestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည 19a, Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great-Grand Daughter Kantrina Kasanda Method of Disposition 20b. Place of Disposition (Name of Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 2 Mo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes After this certificate has been . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 1 Tes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number D62589 2010 22 30. Name and address empleted cause of death (Item 23a) (Type, Print) Heber 1000 Street East Baltimore MI Eager 21202 31. Date filed (Month, 32. Registrar's Signature State Registrar

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8,19a per fh 9906 8-12-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ERNEST DAVIS 5:59 PM 04 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN GOOD BALTIMORE, MD HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Modul Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** XX<sup>M</sup> 2□ F 238-32-1089 Director  $10 - \frac{23}{1923} - 1923$ S.C. Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1√2 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 Corbin Road 21214 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 21215-0036 ģ 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Black Completed ed other than "nature event, the Modical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mill Worker Bethlehem Steel 6th grade Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic even Ferdinand Davis Elizabeth Lofton ပ 19a. Informant's Name/Relationship (Type. Print)

Magwood

Bonnie Maywood—daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. 2122 Corbin Road Balto, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer 4/27/10 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 Scrette 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK, ACUTE RENAL FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): URINARY TRACT INFECTION, STATUS POST CARDIAC Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans requires that the death certificate be exect Due to (or as a consequence of): Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DIABETES MELLITUS CHRONIC KIDNEY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed ALZHEIMERS DEMENTIA of Vital 2 **N**0 1 ☐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Division 1 Natural 5 Pending death. ours after death.

Neral Director: / 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide า 24 hours ar ne Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) waxumal/4 RESIDENT RES-000. 04/20/2010 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLVD, BALTIMORE MD 21239. SHIVAKUMAR NARAYANAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Pablo Jesus Diaz Jr. 17 April 3:30 P.™ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Feb. 4 1 **X** M 2 □ F Days Hours Min. Year 1941 Months 69 218-58-3989 Spain Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location with the Maryland Director 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2523 Hanson Road 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Noivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Packaging Manufacturer Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Pablo Jesus Diaz Sr. Pilar (nmn) Zanz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Paul Diaz / Son 2523 Hanson Road, Edgewood, Maryland, 21040 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 4/20/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ melastatic Carcinoma LIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown cate has been si; page 2 should t Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No |₽ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident 2 Acciden Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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04/17/2010

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31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ap 1911 20, Da 2010 Year Esterlita Villamor de Castro 11:44 Am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 15, Year 947 1 □ M 2 🛭 F Months Hours 62 Philippines Director 216-79-5945 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The start, If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Maryland | Montgomery 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Philippines 20902 11503 Amherst Avenue #203 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Asian 3 🔀 Widowed 4 🗌 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Childcare Nanny Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Esperanza Montemayer Santos Gregorio Villamor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~2090219a. Informant's Name/Relationship (Type, Print) 11503 Amherst Avenue #203, Silver Spring, Maryland Liberty de Castro-Hayes/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot AprilDat21, cemetery, crematory or other place) 1 Durial 2 K Cremation 3 Removal from State Montgomery Crematorium, 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc Bethesda, Maryland 20814 Pumphrey Funeral Home/ c. 7557 Wisconsin Avenue Signature of Funeral Service Licenses do M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Weeks Immediate Cause (Final Ph sician/ disease or condition resulting in death) End-stage Renal Disease Medical Due to (or as a consequence of): Examiner Heparin Induced Thrombosis/Thrombocytopenia Weeks Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Exami Gangrene Right Arm that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Type 2 Diabetes mellitus with Nephropathy Years IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖺 No
9 ☐ Unknown Month Day Year 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Type 2 diabetes mellitus with retinopathy autopsy performe 2 **X**No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed by the attended for use as the burial-trans After this certificate has been si funeral director, page 2 should

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, within 2 To the 1

> State Registrar

Medical

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

suparich Rom D 0065 485

12010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, Maryland 20910 Barbara Ann Supaich, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 15 Pay 20 Year Eleanor Madeline Dillon 10:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10308 Saint Albans Drive Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Month, Day, February 1932 Massachusetts Director 012-24-0842 78 Usual Residence of Decedent show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10308 Saint Albans Drive 20814 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Programmer/Statistician Computers Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည William F. Silva Emma Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Dillon / Son 20305 Brook Run Place, Germantown, Maryland 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April Date 22. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2010 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Puniphrey Funeral Home/Bethesda-Chevy Chase, Inc. the Sten M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Months Physician/ disease or condition resulting in death) Metastatic Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Control of the contro Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown ate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 X No within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 🔲 No Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, D0033293 April 16, 2010

State Registrar 31. Date filed (Month, Day, Year) APR 23

Frederick Pearson Smith, M.D. 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\$2. Registrar's Signature

|                                 |  |                               | Ple<br>Amedn<br>- State Amend #1 I   | ase Type o<br>#17 & 19<br>State<br>per MD G90                    | r Print in<br>a. per<br>of Maryla<br>3 5/7/                   | Black In Fig. 290.<br>Find / Dep<br>10 TT                      | ndelible  <br>2 4/23/1<br>artment o                      | nk. E<br>0 TT<br>Heal    | <b>nsure A</b><br>th and M | II Copie<br>Iental Hy                 | s Are L<br>giene            | egible.                                | 10005  |
|---------------------------------|--|-------------------------------|--|--|---|--|--|--------------------------|----------------------------|---------------------------------------|-----------------------------|--|--|
|                                 | Physicia   | n/                            | Registrar  1. Decedent's Name (First, Middle - Daiel Chris   | le, Last)  |   |  |  |                          |                            | 2. Date of Do                         | nogi no                     | Year                                   | 3. Time of Death                                   |
| ,                               | Medic<br>Examin  |                               | 4a. Facility Name (if not institution Union Memor  |  |   |  | 4b. City, Town   |                          |                            | 09                                    |                             | 20\County of Dea                       | 12:25 PM_  |
|                                 | Funeral<br>Director  |                               | 5. Social Security Number 068-74-4772  | 6. Sex<br>1 M 2 D F  | 7. Age (In yr.  | s. last birthday)<br>Yrs.                                      | If Under 1 Ye Months Day                                 |                          | nder 24 Hrs.<br>urs Min.   | 8. Date of Bi                         |                             | g. Bio                                 | rthplace (State or Foreign ountry) NY              |
|                                 |  | ř                             | Usual Residence of Decedent  10a. State 10b. County  | у  | 10c. City, Town or Location                                   |  |  |                          |                            |                                       |                             |  | 10d. Inside City Limits                            |
|                                 | Marylar<br>28a-f sl  | irecto                        | MD   |  |   | Baltim   |  |                          |                            |                                       |                             |  | 1 XYes 2 □ No                                      |
|                                 | n with the   | Funeral Director              | 10e. Street and Number<br>2714 N. Calv   | ert St.  |   |  | 10f. Zip Cod<br>2121                                     | 8                        |                            |                                       | US                          | n of What Co                           |  |
| 9800                            | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I frem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by                            | 11. Marital Status  1 Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce   | Armed F  | s 2 <b>₹</b> No<br>ive  | If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒No Specify: |  |                          |                            |                                       |                             | Race - Ame<br>Black, Whit<br>ecify: Wh |  |
| 21215-0036                      | n 72 hou<br>e.<br>an "nati<br>Medica   | Be Completed                  | 15. Decede<br>(Specify only high<br>Elementary/Seconday (0-12)   | ent's Education<br>nest grade complete<br>College                | d)<br>(1-4 or 5+)   | (Give  | dent's Usual Occ<br>kind of work dor<br>O NOT use retire | e during                 | most of worki              | •                                     | 16b. Kind                   | of Business                            |  |
| d 21                            | led withi<br>I Hygiene<br>other th   |                               | 7 17. Father's Name (First, Middle,  |  |   |  |  |                          | Mother's Name              | , ,                                   | e, Maiden Sur               | name)                                  | Unk  |
| Maryland                        | ould be fi<br>d Menta<br>marked<br>matic ev  | 입                             | Ralph Angelo   |  | Giorda  |  | na Address (Stre   |                          | rudy S                     |                                       | er City or To               | wn State 7                             | in Code)   |
| , Ma                            | ind 2 shi<br>lealth an<br>im 27 is<br>her trau   | la ele                        | 19a. Informant's Name/Relations Ralph Giordano Ralph Giodan  | <del>o</del> /Fathei   |   | 105  | Fairv  |                          | Cir.                       | Middl                                 | e Isl                       | and,                                   | NY 11953   |
| Baltimore,                      | Page 1 a<br>nent of H<br>ant: If ite<br>ury or otl   |                               | 20a. Method of Disposition  1  Burial 2 Cremation  4  Donation 5  Other  | n 3 ☐ Removal fro  | m State   | cemetery, cre<br>hesape  | osition (Name of<br>matory or other p<br>ake Cr          | em.                      | Apri<br>201                | $\stackrel{\text{\tiny Date}}{1}$ 22, | Belts                       | svill                                  | e, MD  |
| Balt                            | permit. Departi Import any inj   |                               | 21. Signature of Funeral Service   | Licensee Hacker  | mo  | 1565 2   | 2. Name and Add  | dress of F<br>een        | acility AF.                | 1/Step                                | onen L                      | ). Lou                                 | rmann P.A.<br>MD 21286                             |
|                                 | hysician/  |                               | 23a. Part 1. Enter the disease, c<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition | only one cause on a  | each line.  | eath. Do not ent   |  |                          |                            |                                       |                             |  | Approximate<br>Interval Between<br>Onset and Death |
| -                               | Medical<br>Examiner  |                               | resulting in death)  Sequentially list conditions,   | Due to   | o (or as a cons   | equence of):   |  |                          |                            |                                       |                             |  | -2455  |
| 10                              | ansit  | Examiner                      | if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury                                       | Due to   | HIV   | equerice of;   |  |                          |                            |                                       |                             |  | 22 415   |
|                                 | te be executed<br>nysician and<br>ne burial-transit  | l= I                          | that initiated events<br>resulting in death) Last  | d  | o (or as a cons   | equence of):   |  |                          |                            |                                       |                             | _                                      | 3  |
| Box 68760                       | To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death, within 24 hours after death.  To the Luneral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu   | Completed by Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown                              | 1 🔲 Liv  | utcome of preg<br>e Birth 2 ☐ F<br>egnant at time of<br>known | etal death 3   | Ectopic pregn Other (specify,                            | ancy                     |                            |                                       | 230                         | d. Date of de<br>Month                 | elivery<br>Day Year                                |
| s, P.O.                         | res that th<br>sign <b>e</b> d by<br>d be detac  | d by Ph                       | Part II. Other significant condit  | ions contributing to   | death but not   | resulting in the   | underlying cause   | given in                 | Part I.                    |                                       |                             |  | o the cause of death?  Probably 4 Unknown          |
| Division of Vital Records, P.O. | has been<br>ge 2 should  | mplete                        |  |  |   |  | <u>.</u>   |                          |                            |                                       | s an 2<br>opsy<br>formed?   | prior to death?                        | utopsy findings available completion of cause of   |
| al Re                           | ian: The<br>rtificate<br>ctor, pag   | 3e Co                         | 25. Was case referred to medica examiner?  |  |   |  |  |                          | Death (Check               | 1 Yes                                 | 2 XNo                       | 1 ∐ <u>Ye</u>                          | s 2 🗆 No   |
| f Vit                           | Physic<br>this ce<br>al dire   | 년<br>                         | 1 Yes 2 No   |  | Inpatient 2<br>e of injury                                    | ☐ ER/Outpatie  | nt 3 🗆 DOA   | other:<br>4 [<br>jury at | Nursing Ho                 | me 5 Res                              |                             |  | cify)  |
| o uo                            | ending<br>eath.<br>or; After<br>the funer  | Certificate: To Be            | 1 Natural 5 ☐ Pend   | ling (Mo   | onth, Day, Year)  | injury   | M 1  | ork?                     | 2 🗆 No                     |                                       |                             |  |  |
| Divisi                          | tal or Att   |                               |  | 28e. Plac  | ce of Injury - At<br>ding, etc. (Spec                         | home, farm, sti<br>cify)                                       | reet, factory, office                                    | e                        |                            | 28f. Location<br>City or To           | (Street and N<br>wn, State) | umber or Ru                            | ıral Route Number,                                 |
|                                 | e Hospi<br>124 hour<br>e Funer   | Medical                       | (Check 2 Medical   | ng Physician: To the<br>Examiner: On the b<br>ng Nurse Practione | asis of examina   | tion and/or inves  | stigation, in my or                                      | inion, dea               | ath occurred at            | the time, date                        | and place, an               | d due to the                           | cause(s) and manner stated.                        |
|                                 | To the within 2 To the comple  |                               | 29b. Signature and title of certific   |  |   |  | 29c. Lice  |                          | ber<br>3894                | 110                                   |                             |  | h, Day, Year)                                      |
|                                 | ^  |                               | 30. Name and address of person   | m who completed ca   | use of death (It  | em 23a) (Type,   | Print)   |                          |                            |                                       | Apri                        |  | , 2010   |
|                                 | Stat   | te                            | 31. Date filed (Month, Day, Year)  | 23 20 102  | Registrar's Sig   | enorial inature  | Hospit   | 0                        | 201 Ea                     | ist Un                                | iversi                      | ic Yk                                  | Wy Baltimure, MD                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Gilbert Eggen III April 1 20ĬÜ 4:04 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Paul Street Apt.#1701 Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ v M 2 □ F Months Days Hours Min April Day Year 940 219-36-1250 70 Director Maryland Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County at 10c. City, Town or Location Director 10d. Inside City Limits iral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral St. Paul Street Apt.#1701 21202 U.S.A. 1101 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Specify: White or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) External Affairs Specialist Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Gilbert Eggen II Gladdy Armacost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Trojan Horse Drive Phoenix, Maryland 21131 Donna Michael / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Qther (Specify) cemetery, crematory or other place, മ്പർon Park Cem. 4/24/10 Baltimore, Maryland Signature Funeral Service Lice ed 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the dieease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filly one cause on each line. shock, or heart failure. List Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 Ø No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ည 1 🗌 Yes 2 A No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work Accident 1 Yes 2 🗌 No Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Year)

32. Registrar's Signature

| 4 | $^{\circ}$ | വദ | ~ | 25 |
|---|------------|----|---|----|
| 1 | U-         | UJ | v | 20 |

| Richard Joseph   | Fre            | 1- For State   | Sta                      | te of Maryla                           |                       | artment e                          |   |                       | Mental I                    | 30                                  | Reg. No.                | 01               | 0 1252                                      |
|--|----------------|--|--------------------------|--|-----------------------|------------------------------------|---|-----------------------|-----------------------------|-------------------------------------|-------------------------|------------------|---|
| Physici<br>Medical Exami   |                | 1. Decedent's Name (F  |                          | •                                      |                       |                                    | . <u>.                                   </u> | - · · · · ·           |                             | 2. Date of De                       | eath<br>Day             | Year             | 3. Time of Death<br>0420 hrs                |
| Weulcai Exami  | Hei            | 4a. Facility Name (if no   |                          | Freeburg                               |                       | •                                  | 4b. City, 7                                   | Town, or Lo           | ocation of Dea              | April 18,                           |                         | inty of Dea      |   |
|  |                | York Road and  |                          |  |                       |                                    | Luthe   |                       |                             |                                     |                         | more Co          |   |
| Funeral<br>Director  |                | 5. Social Security Num 213-08-149  |                          |  | 7. Age (In yrs.<br>30 |                                    | Month   | er 1 Year<br>Is Days  | If Under 24H<br>Hours M     |                                     | 3irth(MM/DD/Y<br>9/1980 | Fore             | Birthplace (State or<br>Bign<br>Country) MD |
|  |                | Usual Residence of De  |                          | 1 XM 2 F                               | - 50                  | Y                                  | rs.   |                       |                             | 01/0                                | 9/1900                  |                  |   |
| w any  |                |  | b. County                |  |                       | y, Town or Loc                     | ation   |                       |                             | ·                                   |                         |                  | 10d. Inside City Limits                     |
| yland<br>a-f sho<br>t once.  | tor            | MD 10e. Street and Number  | Baltim                   | ore                                    | Spa                   | rks                                | 10f. Zip                                      | Code                  |                             |                                     | 10g. Citizen o          | of Mhat Co       | 1 Yes 2 X No                                |
| the Mai<br>1 or 28   | Director       | 1H Shelby  |                          | h                                      |                       |                                    |   | 152                   |                             |                                     | USA                     |                  | unity:                                      |
| sath with the Maryland<br>items 23a or 28a-f show any<br>ist be notified at once.  | Funeral        | 11. Marital Status   |                          | 12. Was Dece                           |                       |                                    |   |                       |                             | Specify Yes or Note to Rican, etc.) |                         | Race - Ame       | erican Indian, Black,                       |
| er deat  |                | 1 X Never Married 3 Widowed  |                          | 1 Yes                                  | 2 X No                | 1 1                                |   | X No :                |                             | to Moan, etc.)                      | Spec                    |                  | hite  |
| ours aft<br>atural'  | d by           | 15. Decedent's Educa   |                          | or Dates:                              |                       |                                    | nt's Usual                                    | Occupation            | (Give kind o                |                                     | 16b. Kind o             |                  |   |
| 36<br>n 72 ho<br>12 n 12 ho<br>12 n 12 ho<br>15 n 15 n   | Completed      | Elementary/Seconda   | ary (0-12)               | College (1-                            | 4 or 5+)              |                                    |   |                       | O NOT use re                |                                     | 1                       |                  |   |
| -003<br>d withi  | ШO             | 12<br>17. Father's Name (First   | st, Middle, L            | ast)                                   |                       | Autom                              | otive   |                       | Mecha<br>Mother's Nan       | NTC<br>ne (First, Middle            |                         | omotiv           | ve<br>                                      |
| 1215<br>be file<br>mtal Hy<br>rrked o  | Be             | Richard  |                          |  | ger                   |                                    |   |                       | Linda                       | Ann Palr                            | ner                     |                  |   |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumante event, the Medical Examiner must be notified at once. | ٤              | 19a. Informant's Name<br>Linda Ann   |                          |  | •                     |                                    |   |                       |                             | Rural Route Nunit 202               |                         |                  | te, Zip Code)<br>MD 21093                   |
| e, M l and 2 Health item 2   |                | 20a. Method of Disposi   | ition                    |  | 20b.                  | Place of Dispo                     | sition (Nan                                   | ne of ceme            |                             | Date                                |                         |                  | or Town, State                              |
| MOr<br>Pages<br>nent of<br>ant: If   |                | 1 X Burial 2 4 Donation 5  | _                        |  |                       | laney                              | /alley  | y Mem                 | . 04                        | /22/2010                            | ) Timo                  | nium             | , MD  |
| Balti<br>ermit.<br>Separtn<br>mports   |                | 21. Signature of Funera  |                          |  | •                     | 22.                                | Name and                                      | Address of            | Facility To                 | wson, Mi                            | 21204                   |                  | York Road                                   |
| Physician  | $\dashv$       | 23a. Part I. Enter the di  | lisease, or co           | mplications that car                   | used the death        | n. Do not enter                    | ICK (<br>the mode o                           | OWSON<br>of dying, su | huner<br>ch as cardiac      | or respiratory a                    | INC. I                  | . 050<br>r heart | Approximate Interval                        |
| /Medical<br>Examiner   |                | failure. List only of<br>Immediate Cause (Fina                                   | al disease               | each line.<br>a. Multiple Inju         | ries                  |                                    |   |                       |                             |                                     |                         |                  | 8etween Onset and<br>Death                  |
|  |                | or condition resulting in  | ·                        | Due to (or as a ob.                    | consequence           | of):                               |   |                       |                             |                                     |                         |                  |   |
|  | ner            | Sequentially list conditi<br>if any, leading to imme-<br>cause. Enter Underlying | diate                    | Due to (or as a                        | consequence o         | of):                               |   |                       |                             |                                     |                         |                  |   |
| 4 = 5  | edical Examine | (Disease or injury that events resulting in dea                                  | initiated                | c.<br>Due to (or as a c                | consequence o         | of):                               |   |                       |                             |                                     |                         |                  | -   |
| 6, e be executed ysician and burial - transit  | SalE           | UNPENDED   |                          | d                                      |                       |                                    |   | -                     |                             |                                     |                         |                  |   |
| 60,<br>ate be e<br>hysicia<br>e burial   |                | IF FEMALE:   |                          |  | utcome of preg        | nancy                              |   |                       |                             |                                     | 23d. Dat                | e of delive      | IV.   |
| Ox 6876(<br>eath certificate<br>eath certificate<br>a attending phy.   | ian/           | 23b. Was decedent preg<br>past 12 months?  | gnant in the             | 1 Live bir                             |                       | 2 F                                | etal death                                    |                       | Ectopic pregr               | nancy                               | Mont                    |                  | Day Year                                    |
| Box 6876: death certificate the attending phy  | Physician/M    | 1 Yes 2 No 9   | 9 Unkno                  |  |                       | <sup>eath</sup> 5                  | ther (Spec                                    | cify)                 |                             |                                     | İ                       |                  |   |
| , P.O. Boy<br>res that the deatl<br>signed by the att  | by P           | Part II. Other significa   | nt condition             | s contributing to                      | death but not r       | resulting in the                   | underlying                                    | cause give            | en in Part I.               |                                     |                         |                  | the cause of death?                         |
| ds, F<br>equires   | ted            | ·  |                          |  |                       |                                    | _   |                       |                             | 1 Ye                                |                         |                  | obably 4  Unknown utopsy findings available |
| Vital Records, ysician: The law requiins certificate has been a director, page 2 should  | Completed      | -  |                          |  |                       |                                    |   |                       |                             |                                     | psy<br>ormed?           | prior to death?  | completion of cause of                      |
| tal Rection: The certificate   | Be Co          | 25. Was case referred t  | to medical               |  |                       | _                                  | 2   | 6.Place of            | Death (Checl                | 1 Yes                               | 2No                     | 1 🗸 Y            | es 2 No                                     |
| F Vita   | 일              |  | No                       |  | patient 2             | ER/Outpatier                       |   |                       |                             | ing Home 5                          |                         |                  | er: Scene                                   |
| Jing Affe  |                | 27. Manner of Death  1 Natural 5   |                          |  | Day,Year)             | 28b. Time of<br>FOUND:<br>0401 hrs | Injury 2                                      | :8c. Injury a         | at Work?<br>i 2 <b>√</b> No |                                     |                         |                  | ved in motor                                |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director:  | Certification: | 2 Accident 3 Suicide 6   | Investig Could r determi | ot be 28e. Place                       | of Injury - At h      | ome, farm, stre                    | eet, factory,                                 | office build          | ding, etc.                  |                                     | (Street and Nu          | ımber or R       | ural Route Number, City                     |
| Di<br>Hospital o<br>24 hours a<br>Funeral I<br>tely filled   |                | 4 Homicide  29a. Certifier 1 Cer   |                          | ician: To the best                     | Local Stre            |                                    | rred at the                                   | time, date            | and place, an               | 1.                                  |                         | -                | ited.                                       |
| To the Ho<br>within 24 P<br>To the Fu  | edical         | one) 2 Med   | dical Exami              | ner: On the basis of<br>and manner sta | examination a         |                                    |   |                       |                             |                                     | and place, a            | nd due to t      | he cause(s)                                 |
|  | Š              | 29b. Signature and title   | of certifier             | 11.                                    | -                     |                                    | 29c.  | O.C.M.                | 0.6                         | OME                                 | 29d. Date s             |                  | onth, Day, Year)                            |
|  | -              | 30. Name and address   | of person wh             | no completed cause                     | JA, of death (Item    | 23a)                               |   | J. J. 191.            |                             |                                     | 7.011110                | , 2010           |   |
| H  |                | Theodore M. K  | ling, Jr., N             | ID. Assistan                           | nt Medical I          | Examiner                           | 111 Pe  | nn Stree              | et, Baltimo                 | re, MD 2120                         | 1                       |                  |   |
| St.<br>Regist  | _              | 31. Date filed (Month, D   | 9 3 20                   | 10 32. Reg                             | istrar's Signal       | are Low                            | 1   |                       |                             |                                     |                         |                  |   |

|                                 |   |                | State of Maryland / Der State of Maryland / Der State Amend Items 23a,25 per me,g902                               | partment of Health and N<br>.04/22/2010dbb<br>prificate of Death  | lental Hyg   | iene<br>eg. No.2 0 1 0              | 12628                               |  |  |  |  |  |
|---------------------------------|---|----------------|--|---|--|-------------------------------------|-------------------------------------|--|--|--|--|--|
|                                 | - · · ·   | ļ              | Decedent's Name (First, Middle, Last)  |   | 2. Date of Deat  | h                                   | 3. Time of Death                    |  |  |  |  |  |
| -                               | Physicia<br>Medic   |                | Calvert Dorsey Go:   | rman Sr.  | April  | 17° 2010 gear                       | 8:00 P M                            |  |  |  |  |  |
| ~                               | Examin  | er             | 4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location of Death                              |  | 4c. County of Death                 |                                     |  |  |  |  |  |
| - /                             | ·   |                | Salaam Assisted Living Home  | Hanover   |  | Anne Arundel                        |                                     |  |  |  |  |  |
|                                 | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | Months Days Hours Min.  | If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Foreign   Months   Days   Hours   Min.   April 24,1925   Mary Pand   Mary Pand |                                     |                                     |  |  |  |  |  |
|                                 |   | G .            | Usual Residence of Decedent  |   | April 2  |                                     |                                     |  |  |  |  |  |
|                                 | /land<br>f sho<br>ed at   | tor            | 10a. State 10b. County 10c. City, Town or L MD Anne Arundel Glen But   |   |  |                                     | 10d. Inside City Limits             |  |  |  |  |  |
|                                 | 28a-  | Director       | oten but   |   |  |                                     | 1 🗌 Yes 2 🗶 No                      |  |  |  |  |  |
|                                 | ith the   |                | 10e. Street and Number   | 10f. Zip Code   | 1  | I0g. Citizen of What Cou<br>USA     | ntry?                               |  |  |  |  |  |
|                                 | ath w   | Funeral        | 7362 Mockingbird Circle  11. Marital Status 12. Was Decedent Ever in U.S. 13.                                      | 21060 Was Decedent of Hispanic Origin? (Spe                       | ocify Ves or No.   |                                     |                                     |  |  |  |  |  |
| 9                               | or ite  | by F           | 1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give 43-1946  | If Yes, specify Cuban, Mexican, Puerto                            | Rican, etc.)   | 14. Race - Ameri<br>Black, White,   |                                     |  |  |  |  |  |
| 8                               | ırs afi<br>ural",<br>il Exa   |                | 3 ▼ Widowed 4 □ Divorced If Yes, Give 43-1946 Year or Dates.   | 1 ☐ Yes 2 🔀 No Specify:   |  | Specify: Wh                         | ite                                 |  |  |  |  |  |
| 5-                              | 72 hor<br>"nat<br>edica   | ple            | (Specify only highest grade completed) (Give   | dent's Usual Occupation<br>kind of work done during most of worki | ng   | 16b. Kind of Business In            | dustry                              |  |  |  |  |  |
| 72                              | ithin | Completed      | Elementary/Seconday (0-12) College (1-4 or 5+) Mana  | DO NOT use retired)   |  | Grocery                             |                                     |  |  |  |  |  |
| 9                               | lled w<br>I Hygi<br>othel   | Be             | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name   | e (First, Middle, M  |                                     |                                     |  |  |  |  |  |
| Maryland 21215-0036             | d be fi<br>dental<br>urked<br>tic ev  | 7              | John Stevenson Gorman  |   | Rosetta 1  |                                     |                                     |  |  |  |  |  |
| lary                            | should<br>and N<br>is ma  |                |  | ing Address (Street and Number or Rura                            | l Route Number,  | City or Town, State, Zip            | Code)                               |  |  |  |  |  |
| ∑.                              | nd 2 sealth m 27  |                |  | 62 Mockingbird Cir  | cle, Gle   | en Burnie,                          | MD 21060                            |  |  |  |  |  |
| Baltimore,                      | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  |                |  | osition (Name of matory or other place) April                     | _ 22. 1  | 20c. Location - City or T           |                                     |  |  |  |  |  |
| tim                             | it. Pag<br>rtmen<br>rtant:<br>njury   | 3              | 4 □ Donation 5 □ Other (Specify) Glen Have   | n Mem. Park 2010  | )  | Glen Burnie                         | ·                                   |  |  |  |  |  |
| Ba                              | perm<br>Depa<br>Impo<br>any i   |                | 21. Signature of Funeral Service Licensee MO1580   | 2. Name and Address of Facility 1 2                               | Ind. Ave.  | ., SW Glen                          | Burnie, MD                          |  |  |  |  |  |
|                                 |   |                | 23a Part 1. Enter the disease, or complications that caused the death. Do not en                                   | Singleton Fun   |  |                                     | ervices P.A.  Approximate           |  |  |  |  |  |
| i Y                             | Tysician/   |                | shock, or heart failure. List only one cause of each line.   | , ,   |  |                                     | Interval Between<br>Opset and Death |  |  |  |  |  |
|                                 | Medical   |                | disease or condition resulting in death)  a.  Due to (or is a consequence a):                                      | 1. 7.1  |  |                                     | gens                                |  |  |  |  |  |
|                                 | Examiner  | L.             | Sequentially list conditions, b. Celebrovas Char   | disease: strok  | $\mathcal{C}$  |                                     | ijeous                              |  |  |  |  |  |
|                                 | sit sd  | dical Examiner | cause. Enter Underlying  |   |  |                                     |                                     |  |  |  |  |  |
|                                 | ecute<br>and<br>l-tran  | Exal           | Cause (Disease or iinjury that initiated events c  |   | OVED BY  | MEDICAL EXAMINER                    |                                     |  |  |  |  |  |
| 0                               | cate be executed<br>physician and<br>the burial-transit   | ical           |  | CERTIFICAT  | ON APPROVED  | MEDICAL EXAMINER                    |                                     |  |  |  |  |  |
| 3760                            | a 5 =   |                | To service .   |   |  |                                     |                                     |  |  |  |  |  |
| Box 687                         | h cert<br>endin<br>r use  | Physician/Me   | IF FEMALE:<br>  23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1                                 | ☐ Ectopic pregnancy   |  | 23d. Date of deliv                  | rery                                |  |  |  |  |  |
| Bo                              | deatl<br>he atl   | /sici          |  | Other (specify)   |  | Month                               | Day Year                            |  |  |  |  |  |
| Ö                               | requires that the death certific<br>been signed by the attending is<br>should be detached for use as  |                | Part II. Other significant conditions contributing to death but not resulting in the                               | underlying cause given in Part I.                                 | 23e Did tob  | acco use contribute to t            | he cause of death?                  |  |  |  |  |  |
| Division of Vital Records, P.O. | signe<br>d be o   | Completed by   | DIMBETES INELLITUS TYPE 2  | , ,   |  | es 2 No 3 Pro                       | A.F                                 |  |  |  |  |  |
| ord                             | v requisited should   | olete          | BLAGGER CANCEL   |   | 24a. Was an  | 24b. Were auto                      | psy findings available              |  |  |  |  |  |
| Sec.                            | he law<br>te has<br>age 2 s   | omp            |  | y Disease   | autops   | ned? death?                         | mpletion of cause of                |  |  |  |  |  |
| alF                             | ician; The<br>certificate<br>rector, pag  | Be C           | 25. Was case referred to medical   | 26. Place of Death (Check   |  | No 1 Yes                            | TO IN I                             |  |  |  |  |  |
| ₹                               | hysici<br>his ce<br>I direc   | To E           | examiner?  | ent 3 DOA Other: 4 Nursing Ho                                     | me 5 🗆 Reside  | ence 6 Other Specif                 | EU LIVING                           |  |  |  |  |  |
| o c                             | ing P   | ate:           | 27. Manner of Death  28a. Date of injury  (Month, Day, Year)  28b. Time of injury  (Month, Day, Year)              | work?   | 28d. Describe hov  | w injury occurred                   |                                     |  |  |  |  |  |
| ior                             | ttend<br>death<br>stor: /<br>/ the f  | Certificate:   | 2 Accident Investigation 3 Suicide 6 Could not be  | M 1 Yes 2 No  |  |                                     |                                     |  |  |  |  |  |
| Ì                               | after<br>Direction by   | Cer            | 4  Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)                           | reet, ractory, office   | 28f. Location (Str.<br>City or Town,   | reet and Number or Rura<br>, State) | l Route Number,                     |  |  |  |  |  |
|                                 | spita<br>hours<br>neral<br>d filled   | ical           | 29a. Certifier Certifying Physician: To the best of my knowledge, death  | occured at the time, date and place, an                           | d due to the caus  | se(s) and manner as state           | ed.                                 |  |  |  |  |  |
|                                 | To the Hospital or Attending Physician; The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page  | Medical        | (Check 2 Medical Examiner: On the basis of examination and/or inve   | stigation, in my opinion, death occurred at                       | the time, date and   | d place, and due to the ca          | iuse(s) and manner stated. 🏾        |  |  |  |  |  |
| R                               | To t<br>To t  |                | 29b. Signature and title of certified  | 29c, License number   | 25   | 9d. Date signed (Month,             | Day, Year)                          |  |  |  |  |  |
|                                 |   |                | Idan K. Slycan mo  | 1003651   |  | 09/19//                             | >                                   |  |  |  |  |  |
|                                 |   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Jan K. Slepian MD 8028 Ritchie Highw | <sub>Print)</sub> Suite 132<br>Way Glen Burnie, Ma                | arvland  | 20161                               |                                     |  |  |  |  |  |
|                                 | Stat  | е              | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |   | ,  |                                     |                                     |  |  |  |  |  |
|                                 | Registra  | ır             | APR 2 2 2010 Server S. Sa  |   |  |                                     |                                     |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Bigushe 21210 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worthwas a deilis Now Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth Funeral 0/-20-1 🗆 M 💥 🗓 F MD 78 Director 218-28-2059 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director Baltimore X X Yes 2 No 28a-f MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö must be r Funeral USA 21208 1450 Bedford Avenue Apt.#217 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status "natural", or iten edical Examiner r Black, White, etc. African Armed Forces 1 ☐ Yes 2 🛣 No If Yes, Give XX Never Married 2 - Married þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: American Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) oith and Mental Hygiene. 27 is marked other than 'r r traumatic event, the Me Elementary/Seconday (0-12)
10th Grade College (1-4 or 5+) Union Memorial Dietary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Bailey Florence Giddiens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6110 St. Regis Road Baltimore, MD 21206 Health a <u>Yvonne Rugan</u>o-Daughter Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State King Mem. Pk. Cem 04-24-10 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one se on each line Onset and Death Immediate Cause (Final Priysician/ Lypis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospitabor Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown vany opate Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2-1 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No 1 Phopatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 | No Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DUST ho completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 18<sup>Day</sup> 2010 ear Calvin Gordon Ginnavan APRIL 2:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Berlin Nursing & Rehab Center Berlin Worcester 5. Social Security Number 8. Date of Birth (Month, Day, May 30 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 √ M 2 □ F 219-18-6204 85 May Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinating the notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Worcester Ocean City 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1308 Philadelphia Avenue 21842 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Mayes 2 No WWII

If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) GINNAVAN, CALVIN Elementary/Secondary (0-12) College (1-4or 5+) manager telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Ginnavan Anna Cadden ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1308 Philadelphia Ave., Ocean City, MD 21842 B. Ann Ginnavan (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 4-22-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, MD 21784 Much 400764 23a. Part 1. Enter the disease, or complications that caused the death. D ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner alomi Eagle-many list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) has been signed by the eached so 2 should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performe 2 🗆 No 1□Yes 2₩No 1 ☐ Yes After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760.

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Pennie Savage,

31. Date filed (Month, Day, Year APR 2

Da naise

CRNP 9715 Healthway Dr, Berlin,

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) April 19, 2010

21811

MD

|                            |   |                  | For<br>State<br>Registrar  | State of N   | Maryland / Dep<br>Ce                                     | artmen<br>ertificate                      |                              |                     | and N             | lental Hy                        |   | 201                    | 0                   | 126  | 32         |
|----------------------------|---|------------------|--|--|--|---|------------------------------|---------------------|-------------------|----------------------------------|---|------------------------|---------------------|--|------------|
|                            | Physicia  | n/               | Decedent's Name (First, Mide   |  | Gargus   | rimodic                                   | <i>3</i> 0, 2                | Journ               |                   | 2. Date of De                    | Reg. No<br>eath   |                        | T0                  | 3. Time of De 7:30                               | eath<br>PM |
| -                          | Medic   |                  | 4a. Facility Name (if not institution  |  |  | 4b City                                   | Town or                      | Location of         | of Death          | Whili                            |   | . County of            |                     | 7:30   | E M        |
| j                          | Examir  | er               | Collingswood   |  |  |   | ckvi                         |                     | oi Death          |                                  | 40  | . County or<br>Monts   |                     | rv   |            |
| Ī                          | Funeral<br>Director   |                  | 5. Social Security Number 579-01-2150  |  | Age (In yrs. last birthday)<br>89 Yrs.                   |   |                              | If Under<br>Hours   | 24 Hrs.<br>Min.   | 8. Date of Bir<br>Ma V 25        | Birth 9. Birthplace (State or F<br>5ay, Yen 920 Washington, |                        |                     | lace (State or Fo                                |            |
| 61                         |   |                  | Usual Residence of Decedent  |  |  |   |                              |                     |                   |                                  |   |                        |                     | <u> </u>   |            |
|                            | yfand<br>f sho<br>ed at   | tor              | 10a. State 10b. Coun   | •  | 10c. City, Town or L                                     |   |                              |                     |                   |                                  |   |                        | 1                   | 0d. Inside City L                                |            |
|                            | Mar<br>28a-<br>notifie  | )ire             |  | tgomery  | Germa  | antown                                    |                              |                     |                   |                                  |   |                        |                     | 1 🗆 Yes 2  | A No       |
|                            | with the  | Funeral Director | 10e. Street and Number  18011 Chalet D   | rive, #101   |  | 10f. Zip                                  | 208                          | 374                 |                   |                                  | -   | tizen of Wha<br>ted St |                     | -  |            |
| 9                          | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                  | 11. Marital Status  1 Never Married 2 M  | 12. Was Deceden Armed Forces arried 1 \( \sum \) Yes 2 \( \) | ?  | If Yes, spec                              | ify Cubar                    | n, Mexican          | n, Puerto         | cify Yes or No-<br>Rican, etc.)  | -   | 14. Race -<br>Black,   | America<br>White, e |  |            |
| 21215-0036                 | urs aft<br>tural",<br>al Exal   | Completed by     | 3 🕅 Widowed 4 🗌 Divorce  | ed If Yes, Give<br>Year or Dates.                            |  | 1 🗆 Yes                                   |                              |                     |                   |                                  |   | Specify:               | Whi                 | .te  |            |
| 15-                        | 72 ho<br>n "nat<br>fedica   | nple             | (Specify only hig  | lent's Education<br>hest grade completed)                    | (Give  | edent's Usua<br>kind of wor<br>DO NOT use | k done d                     | ition<br>uring mosi | t of worki        | ng                               | 16b. K  | ind of Busir           | ness Inc            | lustry   |            |
| 212                        | within<br>giene.<br>er tha<br>t, the N  |                  | Elementary/Seconday (0-12)   | College (1-4 o   | r 5+)  | omemal                                    | ,                            |                     |                   |                                  |   | Own H                  | lome                |  |            |
| Maryland                   | be filed<br>ental Hy<br>ked oth<br>ic even  | To Be            | 17. Father's Name (First, Middle Lugi Boccabe  |  |  |   |                              |                     | er's Name<br>mela | e (First, Middle,<br>DeGre       |   |                        |                     |  |            |
| ary                        | should<br>and M<br>is mar   |                  | 19a. Informant's Name/Relation   | nship (Type, Print)  | 19b. Mail  | ing Address                               | (Street a                    | nd Numbe            | er or Rura        | l Route Numbe                    |   |                        | e, Zip C            | ode)   |            |
| Σ,                         | nd 2 s<br>lealth<br>m 27  |                  | Jacqueline Gar   | gus / Daught   |  |   |                              | rive                | , #1              | 01, Ger                          | mant  | own,                   | Mar                 | yland 20   | 3874       |
| Baltimore,                 | age 1 a ant of H  |                  | 20a. Method of Disposition  1 X Burial 2 ☐ Crematio                                      |  | te   20b. Place of Disp<br>cemetery, cre<br>  National M | matory or o                               | ther place                   | 9)                  | Apri              | 1 <sup>ate</sup> 23,             | l   | ocation - Ci           | •                   | wn, State<br>1, <b>Virgi</b>                     | inia       |
| altin                      | permit. Pa<br>Departme<br>Importan<br>any injury<br>once.   |                  | 4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Significant                             |  |  |   |                              | -                   |                   | al Home,                         |   |                        |                     |  | ,III.a     |
| <u>~</u>                   | a I De  |                  | Mystetta   | Barrelet   | M01305 30  | 00 West                                   | Mont                         | gomery              | Aven              | ue, Rock                         | ville   | , Mary.                | land                | 20850-286  | 05         |
|                            |   |                  | 23a. Part 1 Inter the disease,<br>shock, or heart failure. Lis<br>Immediate Cause (Final | or complications that caus<br>t only one cause on each li    | ed the death. Do not en<br>ne.                           | ter the mode                              | e of dying                   | , such as           | cardiac o         | r respiratory ar                 | rest,   |                        |                     | Approximate<br>Interval Betwee<br>Onset and Dear |            |
|                            | Medical   |                  | disease or condition<br>resulting in death)  | _ a  | s a consequence of):                                     | ia  |                              |                     |                   |                                  |   |                        | +                   |  |            |
|                            | Examiner  |                  | Sequentially list conditions,  | Perip  | heral Vasc   | ular I                                    | isea                         | ise                 |                   |                                  |   |                        |                     |  |            |
| ^                          | ed sit  | Examiner         | cause. Enter Underlying<br>Cause (Disease or linjury                                     |  | e e consequence of:<br>provascular                       | Accid                                     | lent                         |                     |                   |                                  |   |                        |                     |  |            |
| D.                         | cate be executed<br>physician and<br>the burial-transit   | Еха              | that initiated events<br>resulting in death) Last  | C  | s a consequence of):                                     |   |                              |                     |                   |                                  |   |                        | +                   |  |            |
| 9                          | ate be<br>hysicia<br>the bur  | edical           |  | d  |  |   |                              |                     |                   |                                  |   |                        | _                   |  |            |
| 687                        | ath certifica<br>attending p  | /Me              | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcom  | e of pregnancy   |   |                              |                     |                   |                                  |   | 23d. Date o            | of dollar           | n.   |            |
| Box 687                    | e atter   | Physician/M      | in the past 12 months?<br>1 ☐ Yes 2 🛣 No   | 4 Pregnant   | at time of death 5                                       | ☐ Ectopic p<br>☐ Other (sp                |                              | /                   |                   |                                  | 17/20   | Month                  |                     | Day Year   | r          |
| P.O.                       | at the de<br>d by the<br>etached  | Phys             | 9 Unknown  Part II. Other significant condi  | 9 Unknown  |  | underlyina c                              | ause dive                    | en in Part I        |                   | 220 Did t                        |   | oo oontribu            | to to th            | e cause of death                                 | h2         |
| S, D                       | Attending Physician: The law requires that the death certificate be executed at death.  Ye death.  Sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi  | Completed by     |  | g to count   |  |   |                              |                     |                   |                                  |   |                        |                     | ably 4 🗆 Unk                                     |            |
| ord                        | w require<br>s been si<br>2 should  | plete            |  |  |  |   |                              |                     |                   | 24a. Was                         |   | 24b. Wer               | e autop             | sy findings avai                                 | ilable     |
| Rec                        | The law<br>cate has<br>page 2:  | Som              | ,  |  |  |   |                              |                     |                   | auto<br>perfo<br>1 \(\sum \) Yes | orm <b>ed</b> ?   | dea                    | th?                 | 2 🗌 No   | ie oi      |
| tal                        | ician: The<br>certificate<br>rector, pag  | Be               | 25. Was case referred to medica examiner?  | Hospital:  |  |   | T                            | ce of Deat          | th (Check         | only one)                        |   |                        |                     |  |            |
| Į.                         | Physi<br>this o<br>al dire  | ۰.<br>ح          | 1 Yes 2 X No 27. Manner of Death   | 1 _ Inpa   | itient 2 ER/Outpatie                                     |   |                              | 4 🔼 Nu              |                   | me 5 Resi                        |   |                        | Specify)            |  |            |
| o uc                       | nding l<br>ath.<br>r: After<br>e funer  | icate            | 1 🕅 Natural 5 🗆 Pend   |  | lay, Year) injury  | м 28                                      | 3c. Injury<br>work?<br>1 🗆 ۱ | es 2□               | - 1               | 28d. Describe I                  | now injury  | y occurred             |                     |  |            |
| Division of Vital Records, | or Attendi<br>after death.<br>Director: A<br>in by the fu   | Certificate:     | 3 Suicide 6 Coul   | d not be 28e. Place of Ir                                    | njury - At home, farm, st<br>tc. (Specify)               | reet, factory                             | office                       |                     |                   | 28f. Location (S<br>City or Tov  |   |                        | r Rural             | Route Number,                                    |            |
| ق                          | To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b  |                  | 29a. Certifier 1 🖟 Certifyli   | ng Physician: To the best of                                 | of my knowledge, death                                   | occured at                                | the time.                    | date and r          | place, and        | d due to the ca                  | use(s) an   | d manner a             | s stated            |  |            |
|                            | he Ho<br>in 24 h<br>he Fui<br>ppleted   | Medical          | (Check 2 L Medical   | Examiner: On the basis of<br>ng Nurse Precilioner: Tell      | examination and/or inves                                 | stigation, in r                           | ny opinior                   | n, death oc         | curred at         | the time, date a                 | and place,  | and due to             | the cau             | se(s) and manne                                  | r stated,  |
| 9                          | To the within 2 To the comple   |                  | 29b. Signature and title of certifi  | 7  |  | 29c.                                      | License                      | number              |                   |                                  | 29d. Dat  | te signed (N           | lonth, E            | lay, Year)                                       |            |
|                            |   |                  | - gran   | ~ M·U  |  |   | D3                           | 30132               |                   |                                  | Apr   | cil 19                 | , 2                 | 010  |            |
|                            | 12  |                  | 30. Name and address of person M. Rita Ghosh,  | ·  | death (Item 23a) (Type,<br>Physicians                    | ,   | #161                         | l, Ro               | ckvi              | 11e, Ma                          | ary1a   | and 20                 | 850                 |  |            |
|                            | Stat<br>Registra  | •                | 31. te filed (Month, Day, Year)  |  | trar's Signature   | 200                                       |                              |                     |                   |                                  |   |                        |                     |  |            |

DHMH 17 Rev 7/2009

Pew

| 100            |   |                | State Amend Item 2 Registrar  | _  | d / Depa<br>,04/22<br><i>Cer</i> | artment of<br><b>/2010dhb</b><br><i>tificate of</i> | Health an<br>Death        | d Mental Hy                                 | giene<br>Reg. No.               | 010  | 12633                                       |
|----------------|---|----------------|---|--|----------------------------------|---|---------------------------|---|---------------------------------|--|---|
|                | Physicia  | n/             | Decedent's Name (First, Middle, Last)     Edwin Eugene Harbi                            | •  |                                  |   |                           | 2. Date of De                               |                                 | Year Z                                       | 3. Time of Death                            |
| ~,             | Medic<br>Examin   |                | 4a. Facility Name (if not institution, give s<br>Saint Joseph                           | street and number)   | ter                              | 4b. City, Town,                                     | or Location of D          |   |                                 | nty of Death                                 | 5:ZEF M                                     |
|                | Funeral<br>Director   |                | 5. Social Security Number 6. Sec. 213–28–4442   | x 7. Age (In yrs. Ia   | as <i>t birthd</i> ay)<br>Yrs.   | If Under 1 Year<br>Months Days                      |                           | Hrs. 8. Date of Birt<br>(Month, Da          | th<br>y, Year)<br><b>1,1931</b> | Counti                                       | ace (State or Foreign<br>ry)<br>naton D. C. |
|                | nd<br>how<br>at   | ž              | Usual Residence of Decedent  10a. State 10b. County                                     | 10c. Cit   | y, Town or Lo                    | cation  | -                         |   |                                 |  | d. Inside City Limits                       |
|                | farylar<br>8a-f sl<br>tified  | Director       | Maryland Baltimor   |  | arks-G                           |   |                           |   |                                 |  | 1 Yes 2 No                                  |
|                | the Na or 2   |                | 10e. Street and Number  |  |                                  | 10f. Zip Code                                       |                           | T   | 10g. Citizen o                  | f What Count                                 | ry?   |
|                | th with ms 23 must  | Funeral        | 14203-108 Quail Cr  |  |                                  |   | 21152                     |   | United                          | State  | s   |
| 21215-0036     | ould be filed within 72 hours after death with the Maryland of Mental Hygiene.<br>marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at   | by             | 11. Marital Status  1 ☐ Never Married 2 🔀 Married  3 ☐ Widowed 4 ☐ Divorced             | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1 ☐ Yes 2 【※No<br>If Yes, Give<br>Year or Dates.  | 11                               | Vas Decedent of I<br>f Yes, specify Cub             | an, Mexican, Pu           | ' (Specify Yes or No-<br>uerto Rican, etc.) |                                 | ace - America<br>lack, White, el<br>ify: Whi | tc.   |
| 2-0            | 2 hour<br>"natu<br>edical   | Completed      | 15. Decedent's Edi<br>(Specify only highest grad  | ucation<br>de completed)   |                                  | lent's Usual Occu                                   |                           | workina                                     | 16b. Kind of                    | Business Indi                                | ustry                                       |
| 12             | ithin 7<br>ene.<br>• than<br>he Me  | Com            | Elementary/Seconday (0-12)  | College (1-4 or 5+)  | Îife. Do                         | NOT use retired<br>chanical                         | )                         |   |                                 | INZAC  | 1   |
| 2              | iled w<br>Il Hygi<br>other<br>/ent, t   | Be             | 17. Father's Name (First, Middle, Last)   | N/A  |                                  | charitear   | T                         | Name (First, Middle,                        | Maiden Surnar                   | HVAC   |   |
| ylar           | ild be fill<br>Mental<br>Iarked o   | 2              | Francis Percival H  | arbin  |                                  |   | Corrine                   | e Marie Si                                  | ietz                            |  |   |
| Maryland       | 2 should I<br>th and Me<br>27 is mark<br>traumati   | 9              | 19a. Informant's Name/Relationship (Type<br>Mrs. Patricia Anne                          | . ,  |                                  |   |                           | Rural Route Number                          |                                 |  |   |
|                | and<br>Heal<br>em (   |                | 20a. Method of Disposition  |  |                                  | 3–108 Qu<br>sition (Name of                         | all Cree                  | ek way Sr<br>Date                           |                                 | Lencoe                                       | ,MD. 21152                                  |
| ē              | Page 1<br>nent of<br>ant: If it<br>ury or o   |                | 1 ☐ Burial 2 🛣 Cremation 3 ☐ I<br>4 ☐ Donation 5 ☐ Other (Specify)                      | Removal from State   | emetery, crem                    | eral Cha  | no Tries                  | ril 13,                                     |                                 | •  | , Maryland                                  |
| Baltimore,     | permit. Page Department of Important: If any injury or once.  | 15             | 21. Signature of Funeral Service License  | Jeffrey L. Gair  | 11-                              | Name and Addr<br>aceful Alt                         | ernatives                 | Funeral & Conjum. Mary                      | Cremetia                        |  |   |
|                |   |                | 23a. Pac 1. Enter the disease, or complishock, or heart failure. List only on           | dations that caused the death  | n. Do not ente                   | r the mode of dyi                                   | ng, such as card          | diac or respiratory arr                     | est,                            |  | Approximate<br>Interval Between             |
|                | Ph sician/<br>Medical   | 8 7            | Immediate Cause (Final disease or condition resulting in death)                         | INTRACERE  |                                  | BLEED   |                           |   |                                 |  | Onset and Death                             |
| فمست           | Examiner  |                | Toolaking in dealing  | Due to (or as a consequ  | ence of):                        |   |                           |   |                                 |  |   |
|                |   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter underlying      | Due to (or as a consequ  | ence of):                        |   | _                         |   | 1//                             | /  |   |
|                | executed<br>an and<br>rial-transi   | Examiner       | Cause (Disease or linjury that initiated events resulting in death) Last                | Due to (or as a consequ  | anna of:                         |   | -                         | MANUEL                                      | HEXAMINER.                      |  |   |
| 3              | icate be executed physician and sthe burial-transit   | edical E       | resulting in death) Last  | d.   | ence oij.                        |   | CERTIFICATION             | NAPPROVEDBY MED                             |                                 |  |   |
| 20x 68/        | To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d                   | Ideath 3 🗌                       | Ectopic pregnan                                     | су                        |   |                                 | Date of deliver                              | y<br>Day Year                               |
| 5              | hat the<br>ed by<br>detacl  | by Ph          | Part II. Other significant conditions cor   | ntributing to death but not resu   | ulting in the ur                 | nderlying cause g                                   | iven in Part I.           | 23e. Did to                                 | bacco use cor                   | ntribute to the                              | cause of death?                             |
| as, -          | quires t<br>en sign<br>uld be   | q pa           |   |  |                                  |   |                           | _ 1 🗆 \                                     | res 2 🗶 No                      | 3 Proba                                      | ably 4 🗆 Unknown                            |
| VItal Records, | he law rec<br>te has bec<br>age 2 sho   | Completed      |   |  |                                  |   |                           | 24a. Was a<br>autop<br>perfor<br>1  Yes     | SV/                             | prior to com                                 | sy findings available pletion of cause of   |
| <u> </u>       | ian: T  | BeC            | 25. Was case referred to medical  |  |                                  | 26. P   | lace of Death (C          |   | 2 <b>K</b> J No                 | 1 Yes 2                                      | MAJ NO                                      |
| <u> </u>       | Physic<br>this co   | ۵,             | examiner? 1 Pyes 2 Pyro  27. Manner of Death  | ospital:   |                                  |   | 4 L Nursin                | g Home 5 Resid                              | -                               |  |   |
| n or           | ding th.  | cate           | 1 X Natural 5 Pending 2 Accident Investigation  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of<br>injury           | 28c. Inju<br>wor<br>M 1                             | ryat<br>k?<br>!Yes 2. □No | 28d. Describe ho                            | ow injury occui                 | rred   |   |
| DIVISION       | al or Atten<br>s after dea<br>al Director.<br>ed in by the  | l Certificate: | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At hor building, etc. (Specify)   | ne, farm, stre                   |   | 1103 2 110                | 28f. Location (Si<br>City or Town           |                                 | ber or Rural F                               | Route Number,                               |
|                | he Hospid<br>in 24 hour<br>he Funera<br>pleted filla  | Medical        | (Check 2 \(\sum \) Medical Examina  | cian: To the best of my knowle<br>er: On the basis of examination<br>Practioner: To the best of my | and/or investi                   | gation, in my opini                                 | on, death occurre         | ed at the time, date ar                     | nd place, and di                | ue to the caus                               | e(s) and manner stated.                     |
|                | Voith vith Com  |                | 29b. Signature and title of certifold   | - I M  |                                  | 29c. Licens   |                           | 2   | 29d. Date sign                  | ed (Month, Da                                | ay, Year)                                   |
|                | (5)   |                | moth  | 100, 111   | (V.                              |   | +1234                     |   | 4/                              | 146  | ULU   |
|                | (10)  |                | 30. Name and address of person who co   | mpleted cause of death (Item   |                                  | int)<br>DRIVE                                       | TOWSON                    | WARYL                                       | AND LES                         | 1324   |   |
|                | Stat<br>Registra  | -              | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signat   |                                  | Kal   | - Larger arred N          |   |                                 |  | -   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 4 Month 20<sup>Year</sup>0 Hollev 12:36AM Richard Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Gilchrist Hospice Social Security Number 7. Age (In vrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Hours 05723/T935 Maryland Director 213-32-0677 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nortant in item 27 is marked othe 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4207 Crawford 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Specify: Year or Dates Black 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry
Public Schools of (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Years Principal Balto. City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ Hollev Dennis Nancv Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Holley(Wife) 4207 Crawford Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/23/10 Baltimore, MD Woodlawn Cem. Joseph H. Brown Jr. Funeral Home 21. Signature of Funeral Service Ligenses 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) voden Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ו 24 hours after death.

e Funeral Director: After this certificate has l autopsy performe 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) VVO SQLA ဂ္ 1 🗌 Yes 2 🔊 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Pcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMEI Charles 50 31. Date filed (Month, Day, Year) Registrar's Signatu State APR 23

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 9902 4/23/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death AMonth Month Year **Physician** George W. Hadley 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Baltimore rosedale JUDITE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1**∑** M 2□ F Months 221-14-2874 Yrs 82 Director May 5,1927 Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modes Expresses. 10d. Inside City Limits 10a. State 10c. City, Town or Location MD Director Baltimore 1 ☐ Yes 2 ☐ No Middle River 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Middleway Road Funeral 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∑Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □XNo Specify. <u></u> Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Reeds Company Refrigeration Tech <u>12th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Hadley ပ္ Ruth\_Bartlett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Subock /friend Grove Thorn Road Balto. MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 4/22/10 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD atrick Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner INFECTIVE ENDOCARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☑Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier :ompletely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL 16,2010 00060120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Back River Neck Rd #109 Baltimore, MD 21221 Pankaj Kheterpal

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 23

b

32. Redistrar's Signature

|                   |   |                  | _ State   | aryland / Depa   | artment of Health<br>tificate of Death   |  | the ter 1   | 12636  |
|-------------------|---|------------------|---|--|--|--|---|--|
|                   |   |                  | 1. Decedent's Name (First, Middle, Last)  1. Decedent (First, Middle, Last)   |  | uncate of Death  | 2. Date of Deat                            |   | 3. Time of Death                                   |
|                   | Physicia<br>Medic   |                  | John Peter Hal  | 1  |  | April                                      |   |  |
|                   | Examin  | er               | 4a. Facility Name (if not institution, give street and number) 717 Dorsey Avenue  |  | 4b. City, Town, or Location  |  | 4c. County of Dea                                   |  |
|                   | Funeral   |                  |   | e (In yrs. last birthday)  |  | er 24 Hrs. 8. Date of Birth                | 9. Bi   | rthplace (State or Foreign                         |
| L.                | Director  |                  | Usual Residence of Decedent   | 81 Yrs.  |  | Min. May 3                                 | , 1928  | MD MD  |
|                   | ryland<br>-f shovied at   | ctor             | 10a. State 10b. County MD Baltimore   | 10c. City, Town or Loc   | Essex  |  |   | 10d. Inside City Limits                            |
|                   | the Ma<br>or 28a<br>e notif   | Funeral Director | 10e. Street and Number  |  | 10f. Zip Code  |  | 10g. Citizen of What C                              |  |
|                   | h with<br>ns 23a<br>nust b  | nera             | 717 Dorsey Avenue   |  | 21221  |  | USA   |  |
| 36                | pe 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at  | by               | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Xves 2 □ If Yes, Give Var or Dates   | No I   | Vas Decedent of Hispanic O<br>f Yes, specify Cuban, Mexica<br>☐ Yes 2 👿 No Specify | an, Puerto Rican, etc.)                    | 14. Race - Am-<br>Black, Whi<br>Specify: <b>W</b> ] | te, etc.   |
| 2-00              | hours<br>'natura<br>dical E   | olete            | 15. Decedent's Education (Specify only highest grade completed)   |  | lent's Usual Occupation kind of work done during mo                                | est of working                             | 16b. Kind of Business                               | s Industry   |
| 21215-0036        | ithin 72<br>ene.<br>r than '  | Completed        | Elementary/Seconday (0-12)  12th  College (1-4 or s   | 5+) life. Do   | nanic  | St of Working                              | Havoc   |  |
|                   | should be filed within<br>and Mental Hygiene.<br>is marked other tha<br>'aumatic event, the N   | To Be            | 17. Father's Name (First, Middle, Last)  Albert Hall  | <b>_</b>   |  | her's Name (First, Middle, M<br>arie Schuk | -   |  |
| Maryland          | 2 should<br>Ith and M<br>27 is mar<br>traumati  |                  | 19a. Informant's Name/Relationship (Type, Print) Marie Hall /wife   |  | ng Address (Street and Numb<br>7 Dorsey Av   |  |   |  |
|                   | of Heal<br>of Heal<br>fitem   |                  | 20a. Method of Disposition  1   | 20h Place of Dispo   | sition (Name of  | Date                                       | 20c. Location - City o                              |  |
| Baltimore,        | t. Pag<br>tmen<br><b>tant:</b><br>ijury   |                  | 4 Dopation 5 Other (Specify)  |  | natory or other place)<br>od Cemetery  | L  | Baltimo   | re MD  |
| Bal               | permir<br>Depar<br>Impor<br>any in  |                  | 21. Signature of Funeral Service Ucenses  MUDICULA DUC  |  |  | Funeral H                                  |   |  |
|                   | District on (   |                  | 23a. Eart 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final   | d the death. Do not ente<br>e.   |  | 4  | est,  | Approximate<br>Interval Between<br>Onset and Death |
|                   | Physician/<br>Medical   |                  | disease or condition  | a consequence of   | eurs Lyn   | yshoma                                     |   | one year   |
|                   | Examiner  | er               | Sequentially list conditions, b.  | d consequence on   |  | ,  |   |  |
|                   | uted<br>nd<br>ransit  | Examiner         | fla.y, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.  |  |  |  |   |  |
|                   | ate be executed<br>physician and<br>the burial-transit  | cal E            | resulting in death) Last Due to (or as  | a consequence of):   |  |  |   |  |
| 68760             | ificate I<br>ig phys<br>as the  | Medical          | IF FEMALE:  |  |  |  |   |  |
| Вох               | the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transi | Physician/M      | 23b. Was decedent pregnant 23c. If yes, outcome 1 Live Birth  | 2 Fetal death 3  | Ectopic pregnancy Other (specify)  |  | 23d. Date of de<br>Month                            | elivery<br>Day Year                                |
| P.O.              | that the<br>ned by t<br>detach  |                  | Part II. Other significant conditions contributing to death to  | out not resulting in the u   | nderlying cause given in Par   | t I. 23e. Did tob                          | bacco use contribute t                              | to the cause of death?                             |
|                   | v requires the been signer should be  | ted b            |   |  |  | 1 🗆 Yı                                     | es 2 No 3 🗆 i                                       | Probably 4 🗌 Unknown                               |
| of Vital Records, | The law re<br>ate has be<br>bage 2 sh   | Completed by     |   |  |  | 24a. Was a<br>autops<br>perfor<br>1 □ Yes  | sy prior to<br>med? death?                          | utopsy findings available completion of cause of   |
| tal               | ysician: The lavis certificate hadirector, page 2   | Be               | 25. Was case referred to medical examiner?  |  | 26. Place of De  | eath (Check only one)                      |   |  |
| of V              | g Phys<br>er this<br>eral dir   | e: To            | 27. Manner of Death 28a. Date of inju   |  | 28c. Injury at   | Nursing Home 5 Residence 28d. Describe ha  | ence 6 Other (Spe<br>ow injury occurred             | cify)  |
| ion               | tending Fleath. Or: After the funer.  | Certificate:     | 1  Natural 5  Pending (Month, Date 2  Accident threstigation 3  Suicide 6  Could not be   |  | work?<br>M 1 ☐ Yes 2 [   | □ No                                       |   |  |
| Division          | To the Hospital or Attendi<br>within 24 hours after death<br>To the Funeral Director: A<br>completed filled in by the fi  |                  | 4 Homicide determined 25e. Place of Inj<br>building, et   |  |  | City or Town                               |   |  |
|                   | Hospi<br>24 hou<br>Funer<br>eted fill   | Medical          | 29a. Certifier (Check 2 Medical Examiner: On the basis of a only one) 3 Certifying Nurse. Practioner: To the  | examination and/or invest  | igation, in my opinion, death  | occurred at the time, date an              | nd place, and due to the                            | cause(s) and manner stated.                        |
|                   | To the vithin To the compl  |                  |   | ,  |  |  |   |  |
|                   |   |                  | A   |  | 045  | 5090 F                                     | Toni 25"  | 2010   |
| ·                 |   |                  | 29b. Signature and title of certifier  30 Name and address of person who completed cause of or the complete cause of or the cause of or | Philade Philad | wa Road #  | 208, Ba                                    | Himore,   | ND 21237   |
| 1                 | Stat<br>Registra  | .~               | 31. Date filed (Month, Day, Year)  32. Registr  | ar's Signature   | arke   |  |   |  |

| 10-03053      |  |
|---------------|--|
| James Holiday |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| ames Holiday  |                | State of Maryland / Department of Health and Mental H  1- For State  Certificate of Death  |  | 201   | 0 1263   |
|---|----------------|--|--|---|--|
| Physicia<br>Vledical Examir   | n/             | 1. Decedent's Name (First, Middle,Last)  | 2. Date of Dea<br>Month<br>April 19, 2 | th<br>Day Year                                    | 3. Time of Death<br>1400 hrs                       |
|   |                | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 407 Lyndhurst Street  Baltimore  |  | 4c. County of Dea                                 | th   |
| Funeral   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs   |  | th(MM/DD/YYYY) 9. B                               |  |
| Director  |                | 214-26- 2599 1™M 2□F 78 Yrs. Months Days Hours Min   | July 29                                | , 1931 S&   | ountry) CAROlina                                   |
| v any   | 1              | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |  |   | 10d. Inside City Limits                            |
| Maryland<br>28a-f show<br>datonce,  | ctor           | Haryland MA BAITIMORE  10e. Street and Number 10f. Zip Code  | [1                                     | Og. Citizen of What Co                            | 1 Yes 2 No   |
| with the Maryland<br>ns 23a or 28a-f she<br>be notified at once   | Directo        |  |  | USA   | ····· <b>,</b>                                     |
| hours after death with the Maryland<br>natural", or items 23a or 28a-f she<br>Examiner must be notified at once   | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Married Forces) If Yes, specify Cuban, Mexican, Puerto  |  | White, etc.                                       | rican Indian, Black,                               |
| after de<br>ral", or  | by Fu          | Widowed 4 Divorced in res, Give rear 1 Yes 2 No specify:   |  | Specify:  | Amen ican  |
| 2 3   | eted           | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of votation grade completed)  during most of working life. DO NOT use reti              |  | 16b. Kind of Business                             |  |
| 215-0036<br>be filed within 7<br>ntal Hygiene.<br>rked other thar<br>ent, the Medics  | Completed      | 13th  17. Father's Name (First, Middle, Last)  18. Mother's Name   | (First Middle M                        | School 3  | systems  |
|   | B              | JAMES Holiday SR. MAHIE  | JAM                                    | ES  |  |
| and and mati  | ]٤             | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F   | 2 1                                    | nber, City or Town, State                         |  |
| ore, MD es 1 and 2 sho of Health and If item 27 is her traumati   |                | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date                                   | 20c. Location - City o                            |  |
| Baltimore, permit. Pages 1 a Department of He (important: If its injury or other to   | 4              | 4 Donation 5 Other Specify:  21. 8 gnature of Funeral Service Licensee  22. 5 ame and Address of Facility  | 26,2010                                | LAISOWA   | e MALIAN   |
|   | 4              | Maryel Mi Cerelale 3405 W FRANKLIN St. 1   | BALtimo                                | CE ( MARY 14                                      | nd zieza   |
| Physician<br>\/Medical  |                | Fart I. Endr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. Lift only one cause on each line.  Immediate thuse (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease | or respiratory arre                    | est, snock, or neart                              | Approximate Interval<br>Between Onset and<br>Death |
| Examiner  |                | or condition resulting in death)  Due to (or as a consequence of):   |  |   |  |
|   | iner           | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause  |  |   |  |
| ed<br>isit  | Examiner       | (Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequence of):  |  |   |  |
| execur<br>an and<br>al - tra  | Medical        |  | t                                      |   |  |
| 8760<br>ificate b   | ı√Me           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy   | ancy                                   | 23d. Date of deliver                              | ry<br>Day Year                                     |
| Box 6876 e death certificat the attending phy ed for use as the   | Physician/     | past 12 months?    1   |  |   |  |
| P.O. Bost that the degree by the detached f   |                |  |  | bacco use contribute to                           |  |
| rds, P.C<br>requires that<br>been signed<br>hould be deta   | Completed by   | chronic alcoholism   | 1 Yes                                  | 2 No 3 Pro  | bably 4 ✓ Unknown utopsy findings available        |
| Record The law re   | agm c          |  | autop<br>perfor<br>1 <b>✓</b> Yes      | sy prior to<br>med? death?                        | completion of cause of                             |
| tal Rec<br>cian: The<br>certificate<br>ector, page  | ပ္ကို-<br>မ္က  | 25. Was case referred to medical examiner?   | only one)                              |   |  |
| Division of Vital Records, lat or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should   | 위              | 27 Manner of Death 28a Date of Injury 28b Time of Injury 2 Work?   |  | Residence 6 🗹 Othe                                | er: Scene  |
| ivision  or Attendir after death. Director: A   | catio          | 1 V Natural 5 Pending 2 Accident Investigation   | 000 1                                  |   | I D. d. Nb O't                                     |
| Division At ours after derail Direct filled in by   | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | or Town, S                             |   | ural Route Number, City                            |
| Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri |                | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at       | due to the caus                        | e(s) and manner as sta<br>and place, and due to t | ted.<br>ne cause(s)                                |
| To To Yourth To Com   | Medical        | and manner stated.  29b. Signature and title of certifier 29c. License number  | OME                                    | 29d. Date signed (Mo                              |  |
|   |                | J. Name and address of person who completed clause of death (frem 23a)   | v ::16,                                | April 20, 2010                                    |  |
|   |                | Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore   | e, MD 21201                            |   |  |
| Sta<br>Registi  |                |  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 4 Month Physician/ Eugene Jannon Hyatt Medical Facility Name (if not institution, give street and number, Town, or Location of Death County of Death 4h Examiner Dumie If U 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours Min. (Month, Day, Year Feb. 13. I Country) 216-28-3848 78 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 ☐ Yes 2 🕅 No MD Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 501 Oakwood Station Road U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nopermit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic event. 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 1 Never Married 2 XMarried If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Policeman Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Perry Hyatt Edna Orem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Henrietta Hyatt /Wife 501 Oakwood Station Road Glen Burnie, MD 21061 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of April Date 24 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 2010 4 Donation 5 Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Services 2nd Ave. PA1 SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arre-Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical (or as a consequence of Examiner an con Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No g 🗌 Unknown g 🔲 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No ☐ Yes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to edical 26. Place of Death (Check only one) Hospital 2 1 No မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my only one) 29d. Date signed (Month, Day, Year) d title of certifier 6 Name and address of person who completed cause of death (Nem 23a) (Type, Print) 0

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

23

2

0

32. Registrar's Signature

| State of Maryland / Department of Health and Mental Hygiene  1- For State  Persisters  Certificate of Death  Persisters   |               |   |   |           |   |                    |                |                     |                | 12639                          |           |               |         |   |
|---|---------------|---|---|-----------|---|--------------------|----------------|---------------------|----------------|--------------------------------|-----------|---------------|---------|---|
| Physici   | All           | 1. Decedent's Name (First, Middle,Last)   |   |           |   |                    |                |                     |                | . Date of Deat                 |           | Year          | Ť       | 3. Time of Death                          |
| Medical Exami   | ner           | Sean Carlos Jo  4a. Facility Name (if not institution, give                       |   |           | [4]                                     | o. City. To        | vn. or Lo      | ocation of I        |                | Month<br>April 18, 20          |           | County of D   | eath    | 1119 hrs                                  |
|   |               | 3700 blk Lewiston Avenue  |   |           |   | Baltimo            |                |                     |                |                                |           | N/            |         |   |
| Funeral<br>Director   |               | 5. Social Security Number 6. Sex 212-78-9328                                      |   |           | last birthday)                          | If Under<br>Months | 1 Year<br>Days | If Under 2<br>Hours | 24Hrs.<br>Min. |                                |           | l E           | reign   | place (State or                           |
| Director  |               | Usual Residence of Decedent   | M 2 F   | 40        | Yrs.                                    | Months             | Days           | Tiodio              | -              | Aug.1                          | 8,        | 1969          | Cou     | ntry) MD                                  |
| arry  |               | 10a. State 10b. County  |   | 0c. City  | , Town or Locatio                       | n                  |                | . <u></u>           |                |                                |           |               | 1       | 10d. Inside City Limits                   |
| Maryland<br>28a-f show any<br>1 at once.  | ō             | MD N/   | A   |           | Ba]                                     | timo               | ore            |                     |                |                                |           |               |         | 1 X Yes 2 No                              |
| rth the Maryland<br>23a or 28a-f sho  | Director      | 10e. Street and Number<br>3236 Kenyon Ave   | 20110   |           |   | 10f. Zip C         |                | 24.24.5             | `              | 10                             | g. Citiz  | en of What    |         |   |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once   |               | 11. Marital Status  | 12. Was Decedent Ev                                     | ver in U  | .S. 13. Was                             | Decedent           |                | 21213               |                | cify Yes or No-                | -         |               | SA      | an Indian, Black,                         |
| death v<br>rritem<br>nust b   | uneral        | 1 Never Married 2 XXMarried   | Armed Forces?   | No        |   |                    |                | Mexican, P          |                |                                |           | White, e      |         | ari malari, Black,                        |
| s after<br>rral", o   | by F          |   | f Yes, Give Year<br>or Dates:                           |           |   | Yes 2              |                |                     |                |                                |           |               |         | ack                                       |
| 2 hour  | eted          | 15. Decedent's Education (Specify onl<br>Elementary/Secondary (0-12)              | College (1-4 or 5+                                      |           | 16a. Decedent'<br>during mo             |                    |                |                     |                |                                | 16b. K    | ind of Busin  | ess/In  | dustry                                    |
| 5-0036<br>led within 7.<br>Hygiene.<br>other than   | Completed     |   | 1 year  |           | r                                       | ruck               | . Dı           | iver                | 2              |                                | 5         | Super         | S       | huttle                                    |
| 21215-0036 puld be filed within 7 Mental Hygiene. marked other than c event, the Medical  | a)            | 17. Father's Name (First, Middle, Last)  James Leon John                          | nson III  | Γ         |   |                    | 18             |                     |                | First, Middle, M               |           |               | ~       | J   |
| 2121<br>2121<br>Duld be fi<br>Mental I<br>marked<br>ic event,   | O B           | 19a. Informant's Name/Relationship (Ty  | oe, Print )   | _         | 19b. Mailing                            | Address            | (Street a      |                     |                | a Gert                         |           |               |         |   |
| ore, MD 21215-003 ss 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other their traumatic event, the Mo.   |               | Tonnette Johnson  | on/ Wife  |           |   |                    |                |                     |                |                                |           |               |         | 21213                                     |
| imore, MD 2 Pages 1 and 2 shoument of Health and Nant: If item 27 is nor other traumatic  |               | 20a. Method of Disposition  1 XBurial 2 Cremation 3                               | Removal from State                                      | ·         | Place of Disposit<br>crematory or other | r place)           |                | 4/                  | /26,           | <sup>Date</sup><br>/10         |           | ocation - Cit | •       |   |
| Baltimore, permit. Pages 1 ar Department of Her Important: If ite   |               | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens               | 20  | Ga        | rrison                                  | Fore               | est            | Vet.                | . Ce           | em.                            | Οv        | vings         | M       | ills, MD                                  |
| Balti<br>permit.<br>Departn<br>Imports<br>injury o  |               | 11 110 11   | no  |           | 421                                     | 0 Be               | lai            | r Ro                | Chat           | man-H<br>Balti                 | arı       | ris F         | un<br>D | eral Home<br>21206                        |
| Physician<br>/Medical   |               | 23a. Part I. Enter the disease, or compli-<br>failure. List only one cause on eac | cations that caused th<br>h line.                       | e death   | . Do not enter the                      | mode of o          | lying, su      | ich as card         | liac or r      | espiratory arre                | st, sho   | ck, or heart  |         | Approximate Interval<br>Between Onset and |
| taminer   |               |   | fultiple Gunshot<br>ue to (or as a consequ              |           |   |                    |                |                     |                |                                |           |               | _       | Death                                     |
| The market  |               | Sequentially list conditions, b   | de to (or as a consequ                                  | Jence o   | n).                                     |                    |                |                     |                |                                |           |               |         |   |
|   | miner         | if any, leading to immediate D cause. Enter Underlying Cause                      | ue to (or as a consequ                                  | uence o   | nf):                                    |                    |                |                     |                |                                |           |               |         | ,   |
| sit ed ,  | Ехап          | (Disease or injury that initiated events resulting in death) Last                 | ue to (or as a consequ                                  | Jence o   | f):                                     |                    |                |                     |                |                                |           |               |         |   |
| be executed sician and ourial - transi  | edical        | dd  | AMENDED   |           |   |                    |                |                     |                |                                |           |               |         |   |
| sici  |               | IF FEMALE:  | 23c. If yes, outcome                                    | of preg   | nancy                                   | -                  |                |                     |                |                                | 23d.      | Date of del   | ivery   |   |
| Box 6876( c death certificate the attending physical for use as the b   | sician/M      | 23b. Was decedent pregnant in the past 12 months?                                 | Live birth     Pregnant at tin                          | ne of de  | oth _                                   | l death            |                | Ectopic pr          | regnanc        | У                              |           | Month         | Da      | y Year                                    |
| Division of Vital Records, P.O. Box 6876  Hospital or Attending Physician: The law requires that the death certificate bethours after death.  Funeral Director: After this certificate has been signed by the attending phytely filled in by the funeral director, page 2 should be detached for use as the | 21            | 1 Yes 2 No 9 Unknown  | 9 Unknown   |           | 5 Otne                                  | er (Specify        |                |                     |                |                                |           |               |         |   |
| P.O.  | by P          | Part II. Other significant conditions   | contributing to death b                                 | ut not re | esulting in the un                      | derlying ca        | use give       | en in Part I        |                |                                |           |               |         | e cause of death?                         |
| rds, Frequires  |               |   |   |           |   |                    |                |                     | -              | 24a. Was a                     |           |               |         | bly 4 Unknown  psy findings available     |
| Records, The law require  | Completed     |   |   |           |   | <del></del>        |                |                     |                | autops<br>perforr              | y<br>ned? | prior<br>deat | to co   | mpletion of cause of                      |
| tal Rec   |               | 25. Was case referred to medical  |   |           |   | 26.                | Place of       | Death (Ch           | neck on        | y one) Yes 2                   | No        | 1 🗸           | Yes     | 2 No                                      |
| of Vital<br>ig Physician:<br>ther this certi  | To Be         | 1 Yes 2 No  | spital: 1 Inpatient                                     | 2         | ER/Outpatient                           | 3 DOA              | Ot             | her4[]N             | lursing l      | Home 5 F                       | Residen   | ice 6 🗸 C     | ther:   | Scene                                     |
| n of<br>ding Pl<br>After<br>funera  |               | 27. Manner of Death  1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day Year<br>Apr 18, 2010 | -)        | 28b. Time of Inj                        |                    |                | at Work?            | ls:            | 3d. Describe he<br>ubject shot | ow injur  | y occurred    |         |   |
| Division as after death.  | ertification: | 2 Accident Investigation  | 28e Place of Injur                                      |           |   |                    |                | ding, etc.          |                | Sf. Location (St               | reet an   | id Number o   | r Rura  | al Route Number, City                     |
| Div<br>oital or<br>oral Di  | in in         | 3 Suicide 6 Could not be determined   | (Specify) Local   |           |   | ,,,,,              |                | 91                  |                | or Town, St<br>00 blk Lewis    | ate)      |               |         |   |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | calC          |   | n: To the best of my k                                  |           |   |                    |                |                     |                |                                |           |               |         |   |
| To the I within 2 To the I complet  | Medical       | 2   | ind manner stated.                                      | nation a  | nd/or investigatio                      |                    | icense r       |                     | red at ti      | ne time, date a                |           |               |         | h, Day, Year)                             |
|   | -             | anes  |   |           |   |                    | D.C.M.         |                     |                |                                |           | 19, 2010      |         | n, Day, rearj                             |
| 5   | ŀ             | 30. Name and address of person who co   | mpleted cause of dea                                    | th (Item  | ı 23a)                                  |                    |                |                     |                |                                |           |               |         |   |
|   |               |   | Medical Examin  |           | 111 Penn Sti                            | eet, Bal           | timore         | e, MD 21            | 201            |                                |           |               |         |   |
| St<br>Regist  | ate<br>rar    | 31. DAPR 2'3' 2010"   | 32. Registra's  | Signal    | are                                     |                    |                |                     |                |                                |           |               |         |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number Examiner Itimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral X X**□ M 2□ F 81 Director 231-28-7339 Usual Residence of Decedent 1928 N. Carolina Nov. 3. filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10a. State Yes 2□No Maryland N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 204 21217 USA 342 Bloom Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify:Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Koppers Co. Elementary/Secondary (0-12) College (1-4or 5+) Chipper 5th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Jenkins Addie Gatlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 Bloom Strept.204 Shirley Jenkins/Wife Baltimore Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4/28/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Owings Mills, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Euneral Service License Takris a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final isease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Graem Division or Vital Records, P.O. Box 68760, 🏈 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate I 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 MID 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 SHOAHS A. HASHMI N. EUTAW ST Shite 308 BALTIMOIZE MD 21 401 31. Date filed (Month, Day, Year) State APR 23 2010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Day 19 Physician/ Year 2010 Kaye Jenkins 1813 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimure, MD If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yo June 18 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Hours Country) MD Director 218-40-8287 66 943 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matities at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Sykesville MD Carrol1 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21784 6530 Mellor Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces 1 ☐ Never Married 2 🏋 Married 1 Yes 2 🟋 No Baltimore, Maryland 21215-0036 <sub>Specify:</sub> white 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2<sup>College (1-4 or 5+)</sup> Elementary/Seconday (0-12) health care registered nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Madeline Leppo John Pierce Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6530 Mellor Rd., Sykesville, MD 21784 Mr. Elton Jenkins (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Lake View Memorial 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4-23-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility laight Funeral Home & Chapel 21. Signature of Funeral Service Licens P.O. Box 195 Sykesville, MD 21784 MO0769 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Sercre Lubar Preumunia disease or condition resulting in death) -2 week Medical Examiner Due to (or as a consequence of) 230413 Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown g Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe **Director:** After this certificate It in by the funeral director, page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be within 24 hours are...

To the Funeral Director: Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19/2010 1861627139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nichil Patel University of Maryland Med. Center, 22. S. Greene 16, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State parkel Registrar

**ORIGINAL** 

CHMH 17 Fee 7/9509

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a,25,26,27,29a per dr/me, 2902,04/19/2010dhb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 2010 5:40 P M lartha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harmony Hall Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2 □ F Days Hours 3/14/1921 Yrs Director 174-16-4974 88 PA Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛂 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6529 Carlinda Avenue 21046 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify. 3 XWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Loch Emma Bridenbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Kowalyshyn - Son Severn Drive Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Crestlawn 3/18/10 Marriottsville, MD 4 Donation 5 D Other (Specify) Signature Funeral ervice 22. Name and Address of Facility Harry H. Witzke's Family F.H. Ind. MD 21043 M00845 4112 Old Columbia Pike Ellicott City. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Inter disease or condition resulting in death) cran Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate course [Disease or linjury] Examine Due to (or as a consequence of) SERTIFICATION APPROVED BY MEDICAL EXAMINER been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnan.
Unknown Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) iner? Other: 4X Nursing Home 5 A Residence 6 Other (Specify) 2 1 X Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar 29a. Certifier

only one)

29b. Signature and title of certifier

Dr. Chi

31. Date filed (Month, Day, Year)

APR 23 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8186 Lark Brown Road

2. Registrar's Signature

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Elkridge, MD 21075

Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

058942

2010

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20 TO 5:00 A Kammer Dortha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Lutherville Lyn Court Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Feb. 17 1 M 2 F Lost Creek, WV 235-20-0271 87 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23g or 28a-f chamany injury or other traumatic event, the Madical Examples 2000. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Lutherville MD 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 Lyn Court United States of Americ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Homeowner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Ray J. Boyles Ethel Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1637 Denwright Court Forest Hill, MD, 21050 Ronald J. Kammer/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 04/24/2010 |Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funerai Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician ANTENIO SCIENOTIL CANDIUVAZCUAN disease or condition Medical resulting in death) Due to (or as a consequence of): 20415 Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a doi suguerios ot): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Month signed by the aid be detached f 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRULATION 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Accedin STREILE COLORS UNSCULA this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital: 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural work? 5 Pending Investigation 6 Could not be ☐ Accident ☐ Suicide within 24 hours are.

To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0028812 ant 1 21/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vincent Dipietro Towson MEd. Assoc. 7801 York Rd. Ste. 102 Towson, MD 21204 32. Registrar' Signatu State Registrar

DHMH 17 Rev 7/2009

| Sharon Marie Kn  |   | 1- For State   | State of M   | laryland                                    |                 | rtment of   |                            | and M      | lental Hy                  |                           | Reg. No.                      | 201                            | 0                       | 12644                      |  |
|--|---|--|--|---|-----------------|---|----------------------------|------------|----------------------------|---------------------------|-------------------------------|--------------------------------|-------------------------|----------------------------|--|
| Physicia   |   | Registrar  1. Decedent's Name (First, Middle,Last)   |  |   |                 |   |                            |            | 2. Date of De              | eath                      | 10.25                         | 1                              | 3. Time of Death        |                            |  |
| Medical Exami  |   | Sharon Marie Knisely   |  |   |                 |   |                            |            | Month<br>April 16,         | Day<br>2010               | Year                          | ŀ                              | 1422 hrs                |                            |  |
|  |   | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death   |  |   |                 |   |                            |            |                            | 40                        | c. County of                  | Death                          |                         |                            |  |
|  |   | St. Agnes Hospital   |  |   |                 |   | Baltimore                  |            |                            | _                         |                               |                                |                         |                            |  |
| Funeral  |   | 5. Social Security Number 1372   | 6. Sex   | 7. A  | ge (In yrs. Ia  | ist birthday)   | If Under 1 Y               | _          | Under 24Hrs.<br>Hours Min. | 7                         |                               | h(MM/DD/YYYY) 9. B<br>Fore     |                         |                            |  |
| Director   |   | 212-58- <del>1951</del> -  | 1 M 2  | M 2⊠F 58 Yrs                                |                 |   | Months Bays Thouse Minns   |            |                            | 06/08/1951                |                               |                                | ColM                    | Maryland                   |  |
| -  |   | Usual Residence of Deceder   | 10c. City, Town or Locati  |   |                 | on  |                            |            |                            |                           |                               |                                | 10d. Inside City Limits |                            |  |
| w any  |   | 10a. State 10b. Cou  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         | 1 Yes 2 No                 |  |
| /land<br>-f shc  | ē   |  |  |   |                 | Catonsville   |                            |            |                            |                           | 10a Cit                       | izen of Wha                    |                         |                            |  |
| Mar<br>r 28a   | Director  | 10e. Street and Number   |  |   |                 |   |                            |            |                            |                           | rog. Cit                      |                                | t oodin                 | .,,.                       |  |
| ith the  |   | 518 Marylan  11. Marital Status  | d Ave.   | Voc Docodo                                  | at Ever in 119  | Ever in U.S. 13. Was Decedent of Hispanic Origin? ( S |                            |            |                            | ocify Ves or              | No-                           | USA<br>14 Bace -               | Americ                  | merican Indian, Black,     |  |
| ath w  | Funeral   | 1 Never Married 2  |  | rmed Forces                                 | s?              | If Yes, specify Cuban, Mexican, Puerto                |                            |            |                            |                           |                               |                                |                         |                            |  |
| er de  |   | 3 Widowed 4  | 2 X No   | 1 Yes 2 No specify:                         |                 |   |                            | Specify: W |                            |                           | Whi                           | +0                             |                         |                            |  |
| urs afi<br>tural'  | à   | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kir  |  |   |                 |   |                            |            | Give kind of w             |                           | 16b.                          | 16b. Kind of Business/Industry |                         |                            |  |
| 72 hor   | $\circ$   | Elementary/Secondary (0-   | 12) Co   | ollege (1-4 o                               | r 5+)           | during m  | ost of working I           | life. DO   | NOT use retir              | red)                      |                               |                                |                         |                            |  |
| 036<br>ithin ne.   |   | 12   |  | 1   |                 | Sys   | tems An                    | naly       | st                         |                           |                               | Socia:                         | I S€                    | curity                     |  |
| 5-0036 led within 7 Hygiene. other than  |   | 17. Father's Name (First, Mic  | dle, Last)   |   |                 | =   |                            | 18.M       | other's Name               | (First, Middle            | , Maider                      | Surname)                       |                         |                            |  |
| 121<br>I be fi<br>ental l<br>arked   | Be  | George Donoghue Frances Serio  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         | 7:- O-d-)                  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Realth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | 은   |  |  |   |                 | 1   |                            |            |                            |                           |                               |                                |                         |                            |  |
| , MD<br>and 2 sho<br>salth and<br>cm 27 is   | H   | Carey Sczepu  20a. Method of Disposition   | cha / S  | Son   | 20b. P          |   | tonewal                    |            |                            | Catons<br>Date            | VIII.<br>20c.                 | Location - C                   | City or T               | and 21228 _<br>own, State  |  |
| Baltimore,<br>permit. Pages 1 ar<br>Department of Hee<br>Important: If ite   |   | 1 Burial 2 Crema   | ition 3 🔲 Re   | moval from S                                | State C         | rematory or ot  | ner place)                 |            |                            |                           |                               |                                |                         |                            |  |
| t. Pag<br>trent<br>rent  |   |  |  |   |                 |   |                            |            |                            |                           | / 22/10   Baltimore, Maryland |                                |                         |                            |  |
| Bal<br>permi<br>Depar<br>Impo<br>injur   |   | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 3620 Wilkens Ave. Baltimore, Mark Fundament Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 22. Name and Address of Facility Loudon Park Fundament Service Licensee 23. Name and Address of Facility Loudon Park Fundament Service Licensee 24. Name and Address of Facility Loudon Park Fundament Service Licensee 24. Name and Address of Facility Loudon Park Fundament Service Licensee 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Address of Facility Loudon Park Fundament Service 24. Name and Addr |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| Physician  | 4   | 23a. Part / Enter the disease  | or complication  | ns that cause                               | ed the death.   | Do not enter t  | 20 W11K<br>ne mode of dyir | ng, such   | AVE.                       | r respiratory a           | arrest, sh                    | ock, or hear                   | t                       | Approximate Interval       |  |
| Mortani  | 9 9   | failure. List only one co  | use on each line   | ole Injurie                                 |                 |   |                            |            |                            |                           |                               |                                |                         | Between Onset and<br>Death |  |
| Examiner   |   | Immediate Cause (Final sister or condition resulting in deaf   |  |   | sequence of     | ):  |                            |            |                            |                           |                               |                                |                         |                            |  |
|  | .   | Sequentially list conditions, b  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last   |   |  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
|  |   |  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| an and al - transi   |   |  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| . o .o.c.  | dical   | UNPENDED #5perFH,G902,4/28/2010,WS   |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| 30x 68760<br>death certificate b<br>e attending physi  | §   | IF FEMALE:<br>23b. Was decedent pregnant   | 23c  | . If yes, outc                              | ome of pregr    | nancy   |                            |            | ctopic pregna              | PO.                       | 23                            | ld. Date of d<br>Month         | lelivery<br>Da          | av Year                    |  |
| certif   | /sician/Me  | past 12 months?  4 Pregnant at time of death 5 Other (Specify)   |  |   |                 |   |                            |            |                            | egnancy                   |                               |                                | De                      | ay real                    |  |
| Box<br>e death c<br>the atten<br>ed for us   | Ş   | 1 Yes 2 No 9 V Unknown 9 Unknown   |  |   |                 |   |                            |            |                            |                           | İ                             |                                |                         |                            |  |
| s, P.O. Bc<br>ires that the dee<br>signed by the z   | / Phy   | Part II. Other significant co  | nditions contri  | buting to dea                               | ath but not re  | sulting in the u                                      | inderlying caus            | se given   | in Part I.                 |                           |                               |                                | _                       | ne cause of death?         |  |
| res th   | d by  |  |  |   |                 |   |                            |            |                            | 1Y                        | es 2                          | ✓ No 3                         | Proba                   | ably 4 Unknown             |  |
| rds<br>requ  | 24a. Was an autopsy performed?  1 ✓ Yes 2 No 1  25. Was case referred to medical  26. Place of Death (Check only one) |  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| eco<br>he lav<br>tte has   |   |  |  |   |                 |   |                            |            |                            | ath?                      | 2 No                          |                                |                         |                            |  |
| nn: T<br>artifica<br>tor, pa   |   |  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| Vita<br>his ce<br>direc  | To B  | examiner?<br>1 ✓ Yes 2 No  | Hospita  | l: 1 Inpa                                   | tient 2 🗸       | ER/Outpatient   | 3 DOA                      | Othe       | 4 Nursin                   | g Home 5                  | Resid                         | ence 6                         | Other:                  |                            |  |
| Of ng Ph   |   | 27. Manner of Death  | 28   | Ba. Date of Ir<br>(Month Day<br>Apr 16, 201 | njury<br>(Year) | 28b. Time of I  | · ·   _                    | Injury at  |                            | 28d. Describ<br>Driver of |                               |                                |                         | with fixed                 |  |
| ion<br>ttendi<br>leath.<br>tor:  | 읋   |  | Pending F<br>nvestigation  | Apr 16, 201                                 | 0               | 1314 hrs  | 1_                         | Yes        |                            | object                    |                               |                                |                         |                            |  |
| ivision or Attendather death Director:   | ertification:   | 3 Suicide 6  | de 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. |   |                 |   |                            |            |                            | or Town                   | , State)                      |                                |                         | al Route Number, City      |  |
| Spital spital hours.   | Ö   | Homicide determined (Specify) Major Road / Highway Frederick Road and River Road , Catonsvile,  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| Division of Nether Hospital or Attending Phermin 24 hours after death. To the Funeral Director. After templetely filled in by the funeral  | edical  |  |  |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| To the Comp  | Medi  | and manner stated.   |  |   |                 |   |                            |            |                            |                           | 29d. Date signed (Month, Day, |                                |                         |                            |  |
|  | -   | Maure To M. M. 12  |  |   |                 |   |                            |            | O.C.M.E.                   |                           |                               |                                | April 17, 2010          |                            |  |
|  |   | John and addings of  | person who completed cause of death (Item 23a)   |   |                 |   |                            |            |                            |                           |                               |                                |                         |                            |  |
| 1  |   | 30. Name and address of permanents of the Margarita Korell M   |  |   | al Examin       |   | enn Street,                | , Baltir   | more, MD                   | 21201                     |                               |                                |                         |                            |  |
| St   | ate   | 31. Date filed (Month, Day, Y  |  |   | rar's Signatu   | re -  |                            |            |                            |                           |                               |                                |                         |                            |  |
| Regist   |   | APR 2  | 3 2010   | Denes                                       | un h            | 9. Sa   | Mal                        |            |                            |                           |                               |                                |                         |                            |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ April 20 2:57p William Reid Kennedy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 2118 Havre de Grace Sherwood Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 1271471921 Minnesota **Director** 049-05-3592 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Examiner must be notified at Director 1 Tes 2 No Harford Havre de Grace Maryland 10e. Street and Number 10g. Citizen of What Country? ò 23a Funeral 21078 USA 2118 Sherwood Lane or items death 12. Was Decedent Ever in U.S. Armed Forces? 1940- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. <sup>2 No</sup> 1962 þ 1 Never Married 2 K Married Yes Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Civil service 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Augusta Albrecht William R. Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2118 Sherwood Lane, Havre de Grace, MD 21078 Elisabeth Kennedy (wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/20/2010 Arlington, Virginia Arlinton National Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen. Marvland 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) yeurs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a detached 1 P.O. I signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 Tho 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 🗂 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certificate: Natural ( 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 E Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who completed ca 4940 EArieAr AVR BALTIMORE MAZIZZY VATELL HB MILHARL

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registra Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Mary Grace Licata 12:00 PM April 21, 2010 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 219-10-6544 Feb. Maryland 6, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6838 Queens Ferry Road 21239 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: Specify. 3XXWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Beauty Technician Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Alberti Dominica Torressi 19a. Informant's Name/Relationship (Type. Print) Grand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Bel Air South Pkwy. #109-7 Bel Air, Md. 21015 Joshua A. Shores, Sr./ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grd. 4/23/10 | Timonium, Maryland 4□Donation 5 \ Other (Specify) Entomb 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home. Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Rapidly worsening pleural effusion and enlarging Right mass N 1-2 Weeks disease or condition resulting in death) umbar osteomyelitis i abscess 72 weeks Due to (or as a consequence of) Lung cancer è widespread metastasis 71 year Due to (or as a consequence of) Coronary artery disease IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 □ Yes 2 ☑No 2 🗆 No 25. Was case referred to medical

**Physician** /Medical Examiner

signed by the a

page 2

certificate

24 hours after death.

Funeral Director: After thi etely filled in by the funeral to

completely

To the I within 2 To the I

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Completed

Be

Certification: To

Medical

certificate be executed

Box 68760

P.0.

Division of Vital Records,

Hospital or Attending Physician: The

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Directo

Funeral

2

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, If a Medical Examinat must be notified as

Baltimore, Maryland 21215-0036

icata, Mari

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia, Diabetes mellitus, hypothyroidism

hypertension

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier Dimaand, M.D.

5 Pending

investigation

6 Could not be determined

D0065809

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dimaano, Greater Baltimore Medical Center Paras Gerard 32. Registrar's Signature 31. Date filed

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 April Physician/ Jacqueline T. Lefton 10:50 PM 20 . Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice Casey House Rockville , Social Security Number If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🍱 Hours Min June 1, 1951 506-74-4128 58 North Dakota Director Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Exaπiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 🗌 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 313 Ridgepoint Place 20878 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Educator Elementary School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jacob Aipperspach Alma Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew B. Lefton/Husband 313 Ridgepoint Place, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ApriDite 24. permit. Page 1 Department of Important: If it any injury or o Parklawn Memoriate Park 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 2010 Rockville, Maryland Rockville; Maryland 20850 Montgomery Avenue Signature of Funeral Service License M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician Ovarian Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 Nes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice Inpatient examiner? Hospital 1 Tyes 2 🛛 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tyes 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

Registrar

(0

State

6001 Muncaster Mill Road, Rockville, Maryland 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatore

Diane Ruckert, CRNP

31. Date filed (Month

April 21, 2010

Amend Items State of Maryland / Department of Health and Mental Hygiene Of Mental Hy for State Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Myers Physician/ Martin Month 2015 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year If Under 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 7 /57 19 18 213-05-1279 93 Yrs Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MDCarroll Westminster 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 36 Goni Terrace 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Repair Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ot ပ္ Charles Franklin Myers Clara Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise G. Myers-wife Goni Terrace, Westminster, MD 21157 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State South Carroll Crem 4/19/10 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Nome 21. Signature of Juneral Service Licen Thomas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each # Interval Between Immediate Cause (Final Onset and Death veum om a Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a co by the attending physician and stached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a co CERTIF Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [ك Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate 1 ☐ Yes 2 ☐ ₩6 25. Was case referred to medical funeral director, B 26. Place of Death (Check only one) examiner? Certificate: To Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manual of Death 28a. Date of injury 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Subject tripped and fell; Subject fell out of bed. 03/11/2010 a ural 5 Pending 2 X Accident 1 Tyes 2 No Unknown M Investigation 6 Could not be in by the 04/10/2010 3 Suicide 4 Homicide 28f. Location (Street and Number of Rural Route Number of Rural Ro 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Front steps at office; Home determined within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 29d. Date signed (Month, Day, Year) 039JDDM3 Nagle and address of person who completed cause of death (Item 23a) (Type, Print) main street westminster My UINT State 32. Registrar's 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Items 23alper dr.,g904.06/29/2010dhb

Certificate of Death

Reg No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month April Physician/ 10,2010 Marsh 0.0 20 Vanessa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hill PG Southern Maryland Hosp 8. Date of Birth
(Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Country) 1 □ M 2 🖵 F 577-90-8880 1961 D.C Director 49 Usual Residence of Decedent show 10d Inside City Limits 10a. State 10b County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director Temple Hill MD PG 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 Funeral 2609 Iverson Street USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black White etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 № No Specify: Specify Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) N/A Elementary/Seconday (0-12) Security Co. e 1 and 2 should be filed withing the filed withing the file of Health and Mental Hygien of Health and Mental Higher the file of the traumatic event, the 12th Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Vera Mae Strickland Fred Douglas Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Iverson St. Temple Hill, MD 20748 Mark L. Marsh/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₹ permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4/23/10 Woodbine, 4 Donation 5 Other (Specify) Final Journey . Signature of Funeral Service Licenses 22. Name and Address of Facility Charisse N. Woods 2122 3 2700 Edmondson Ave. Balto., MD un Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 Physician/ disease or condition Medical resulting in death) Due to (or as a co sequence of) Examiner Diabetes Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Litter or denying Cause (Disease or iinjury Tracheostomy or Attending Physician: The law requires that the death certificate be executed 9 che03 the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has the lirector, page 2 s autopsy performed? 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this eted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation within 24 hours after des To the Funeral Director completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Gertifying Prijaction: To the basis of examination and/or investigation, in my opinion, death pocurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04/10/10

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DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29a, per DVR g902 4/23/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2010 HELEN /Medical BALTIMORE MARYLAND
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Month, Day,
Dec. 9, 4a. Facility Name (If not institution, give street and number) TOHNS 4c. County of Death Examiner BALTIMORE BAYVIEW GERIATRIK CENTER CII Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2√E 97 217-05-2410 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Essex MD 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 948 Kayden Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married limore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Mesonce. Elementary/Secondary (0-12) College (1-4or 5+) Mary Sue Candy Co. Candy Packer 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be unknown unknown ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 948 Kayden Lane Baltimore MD 21221 James Machniak /son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMEN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-t Due to (or as a consequence of) Box 68760, attending physician for use as the buria the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No P.O. cate has been signed by the a page 2 should be detached to 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician; To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X**No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide TS-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R114997 embomilla CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS CIRCLE VIEW GALTIMORE. MARYLAND 31. Date filed (Month, Day, Year) APR 23 32. Registrar's Signature State 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19,2010 4:30p M James Melka April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6926 Gunder Avenue Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign April Day, Year) 218-05-3359 1 M 2 🗆 F Hours 88 ,1921 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f slevent, the Medical Examiner must be notified Baltimore MD Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6926 Gunder Avenue 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) College (1-4 or 5+) Martin Marietta Metal Plater 3rd Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Melka Mary Vich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Melka /son 6334 Rowanberry Drive Elkridge MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burjaj , 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Holly Hill Cemetery 4/24/10 Baltimore MD on 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave.\_Balto. MD ice Lirensee Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ DEMENTIA-STAGE disease or condition ) Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 2 Besidence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number austo D4000

State Registrar 31. Date filed (Month

FRANKLIN SQUARE

ME

30. Maple and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Abraham 210° 20°° 0 6:27P M George Myers 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign July 5, 1934 Months Days Hours Min. 75 212-32-6972 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Fourth Avenue S.W. 21061 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Florist Florist Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham T. Myers Alice R. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Henry Myers/ Brother Fourth Avenue SW Glen Burnie, MD, 21061 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 25 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2010 Glen Burnie, MD 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ACUTE GASTROINTESTINAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: Due to (or as a consequence of): 23d. Date of delivery

Physician/ Medical Examiner

that the death certificate be executed

has

certificate

Box 68760

P.O. |

Division of Vital Records, Hospital or Attending Physician: The law requires Physician/

Medical

Director

Funeral

Completed by

Be

**Examiner** 

**Funeral** 

Director

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items

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permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal

72 hours after

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Exami attending physician and for use as the burial-tran Physician/Medical signed by the a þ Completed page 2 Be within 24 hours after death.

To the Funeral Director: After this c ည

25. Was case referred to medical 27. Manner of Death Certificate:

Medical

resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner' 1 🗌 Yes

1 Natural

☐ Accident

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check

only one) 29b. Signature a

Suicide

2 MO

5 Pending

Investigation

determined

6 Could not be

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Pregnant at time of death

28a. Date of injury

(Month, Day, Year)

5 Other (specify) 9 Unknown

Ectopic pregnancy

Month

2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 LeR/Outpatient 3 I DOA 28c. Injury at 28d. Describe how injury occurred

28b. Time of work? 1 🗌 Yes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D31136

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SRIAN C. WALLACE, WD 9005

KILBRIDE RP. BACTIMORE, MID 21236

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25,27, perphys, 6902,4723/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1150AM Anne Noeth Miles 055 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A C.tc Balton Ihm Dinai Hoppital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🖵 F Months Hours 216-46-4843 87 8775/1922 Mary and Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director Baltimore 1 🗌 Yes 2 🙀 No Maryland Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road Apt F210 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: 3 Divorced 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harry Noeth Henrietta Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Eugene L. Miles, Jr. / Husband 2300 Dulaney Valley Road Apt F210 Timonium, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State 4/24/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) New Cathedral Cemeter'v 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DENTIFICATION APPROVED BY MEDICAL ELAMINES Physician/ ubdural Hematoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ŏ in the past 12 months?

1 Yes 2 No Month ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sate has been sign page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Avo 1 Yes 2 KNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 

☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral filled in by the fun 0506AM Natural 5 Pending 2 Accident -all 121/2010 1 Yes 2 🗹 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place f Injury - At home, farm, street, factory, office building, etc. (Specify). 28f. Location (Street and Number or Ryral Route Number, City or Town, State)
2300 DulaNey Valley Rd. determined tome Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated as Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066614 April 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sirai Hospital of Baltimore Jennifer Berkeley, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#30perDVR, G902, 472372010, WS State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ langle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Security Number **Funeral** 1 M 2 D F Days Hours Min Country) Director Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Z Yes 2 No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. P. ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. sant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 FFICEC Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည aiers 01 traumatic ppenKemp 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) portant: If item 27 is vinjury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date JNK 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) tro remotor 21. Signatu e of Lin / Service Lice 22. Name and Addre Dr. Jessup, PA 18434 23a. Part 1 Enter the disease, or complication shock, or heart failure. List only one cau wused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, nice melas cre Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami for use as the burlal-transif Cause (Disease or iinjury that initiated events resulting in death) Last sate has been signed by the attending physician and page 2 should be detached for use as the burlal-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 WNo 4 Pregnant at time of death 9 Unknown Month Year 5 Other (specify) Day g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy 2 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) Hospital 2 No 2 1 Yes 2 ER/Outpatient 3 DOA npatient 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 2 10 20 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4AVROMA 904 Seton Dr. Cumberland, MD 21502 31. Date filed (Month, Day, Year, 32. Registrar's State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year April 21, McGuirk С. 1:00 a<sup>M</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville <u>2 G S</u>tayman Ct. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 18, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1 X M 2 □ F 216-24-8604 1930 79 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 217 No Baltimore Catonsville Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 2 G Stayman Ct. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Tyes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2K Married White 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MTA Bus Driver 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I. E. McGuirk Beatrice Bernard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 G Stayman Ct., Catonsville, MD 21228 Jean T. McGuirk (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 4/26/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPHAGEAL IETASTATI Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

permit, Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, III

Physician

/Medical

**Examiner** 

**Funeral** 

Director

or than "natural", or items 23a or 28a-f show

Director

by Funeral

Completed

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Be Certification: To

3 ☐ Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier

cate has been signed by the attending physician page 2 should be detached for use as the hirrial certificate

within 24 hours after deat To the Funeral Director:

cal

Registrar

ST AGNES 31. Date filed (Month, Day, Year)

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE MD 900 C

1 ☐ Yes 2 ☐ No

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:50 AM Apri Murray Miller, Jr. L. 17 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □XM 2 □ F 219-22-3681 May 13, 1927 Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Marical Examinar must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1125 Circle Drive 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 □ No If Yes, Give Year or Dates: 1945-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. Claims Examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miller, Sr. Gladys Virginia 2 Murray Downing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau Fay C. Miller (Wife) 1125 Circle Dr., Baltimore, MD 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery: 4/21/10 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 Days **Physician** Preumonio /Medical Due to (or as a consequence of) Examiner Pulmonary Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical AY IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed funeral director, page To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate t 2 **4**0 1 □ Yes 1 ∐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

ZAR

A

Cation

32. Registrar's Signature

P-24064

M.D

900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

MD - 21229

04/17/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |   |                           | For<br>State<br>Registrar  | State of M   | 1arylan          |                          | artmen<br><i>tificate</i> |                     |                        | and M           | 1ental Hy                        | /gien<br>Reg. N | 2111   | 0             | 125                                      | 57         |
|----------------------------|---|---------------------------|--|--|------------------|--------------------------|---------------------------|---------------------|------------------------|-----------------|----------------------------------|-----------------|--|---------------|--|------------|
|                            |   |                           | 1. Decedent's Name (First, Middle, Last) 2. Date of Death                |  |                  |                          |                           |                     |                        |                 |                                  |                 | 3. Time of D                                     | eath          |  |            |
|                            | Physicia<br>Medic   |                           | Her  | man Francis  | Mars             | chik,                    | Jr.                       |                     |                        |                 | Month<br>Apri                    | $1 1^{0}$       | 7, 2010  | ar<br>)       | 4:02PM                                   | М          |
|                            | Examir  |                           | 4a. Facility Name (if not institution, g                                 | ive street and number)                               |                  |                          | 4b. City,                 | Town, or            | Location c             | of Death        | _                                |                 | c. County of E                                   |               |  |            |
|                            |   |                           |  | an Hospital  | L                |                          |                           |                     | Bethe                  | esda            |                                  |                 | M <sub>C</sub>                                   | onts          | omery                                    |            |
|                            | Funeral   |                           | 5. Social Security Number 6  | . Sex 7. As<br>1 M 2 □ F                             | ge (In yrs. la   | **                       | If Under<br>Months        | 1 Year<br>Days      | If Under               | 24 Hrs.<br>Min. | 8. Date of Bit<br>(Month, Da     | av. Yearl       | 9.   | Birthpl       | ace (State or I                          |            |
|                            | Director  |                           | 198-22-1706 Usual Residence of Decedent                                  |  | 81               | Yrs.                     |                           |                     |                        |                 | Januar                           | ý7,             | 1929   I   | enr           | <u>ı́sylvan</u>                          | ia         |
|                            | nd<br>how   | =                         | 10a. State 10b. County   |  | 10c. City        | , Town or Loc            | ation                     |                     |                        |                 |                                  |                 |  | 10            | d. Inside City                           | Limits     |
|                            | anyla<br>a-f s<br>fied  | <del> </del>              | Manual and Mone  | tgomery  |                  |                          |                           | D.o.                | ckvi1                  | 11.             |                                  |                 |  |               | 1 X Yes 2                                | 2 🗆 No     |
|                            | he M<br>or 28<br>e not  | Funeral Director          | Maryland Mont  | Lgomer y   |                  |                          | 10f. Zip                  |                     | CKVII                  | LIE             |                                  | 10g. C          | Citizen of What                                  | t Count       | rv?                                      |            |
|                            | with t  | era                       | 511 And  | erson_Avenu  |                  |                          |                           |                     | 20850                  | )               |                                  |                 | Unit   |               |  |            |
|                            | eath<br>tems  | ا جًا                     | 11. Marital Status   | 12. Was Decedent                                     | Ever in U.S      | . 13. V                  | Vas Deced                 |                     |                        |                 | cify Yes or No-<br>Rican, etc.)  | -               | 14. Race - A                                     |               | n Indian,                                |            |
| 9                          | ter d<br>, or it  |                           | 1 Never Married 2 X Married  |  |                  |                          |                           |                     | n, Mexican<br>Specify: |                 | Rican, etc.)                     |                 | Black, V   | Vhite, e      | tc.                                      |            |
| 8                          | ursal<br>ural"  | ted                       | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates.                       |                  | '                        | ⊔ Yes                     | Z EN INO            | Specity:               |                 |                                  |                 | Specify:   | W             | hite                                     |            |
| 5-(                        | 2 hot<br>"nat   | Completed by              | 15. Decedent's<br>(Specify only highest                                  | s Education<br>grade completed)                      |                  | 16a. Deced<br>(Give k    | ind of wor                | k done d            | ation<br>uring most    | of workii       | ng                               | 16b.            | Kind of Busine                                   | ess Ind       | ustry                                    |            |
| 7                          | thin 7<br>ane.<br>than  | ĕ                         | Elementary/Seconday (0-12)   | College (1-4 or                                      | 5+)              |                          | NOT use                   | ,                   |                        | ^               |                                  |                 |  |               |  |            |
| 2                          | ed wi<br>Hygie<br>other   | Be (                      | 17. Father's Name (First, Middle, Las                                    | <i>t</i> )   |                  | пез                      | avy E                     | quip                | ment                   |                 | (First, Middle,                  | Maida           | Consti   | cuct          | 10n                                      |            |
| an                         | be file<br>antal<br>ked c   | 흔                         |  | •  | h d 1.           | . C.,                    |                           |                     | 10. MOLITE             | er s marne      | Mary                             | , iviaidei      | i Surriame)                                      |               |  |            |
| Maryland 21215-0036        | ould Me mar   | l                         | 19a. Informant's Name/Relationship                                       | Francis Mar  | SCIIIK           |                          | a Address                 | (Street a           | and Numbe              | r or Pura       |                                  | or City o       | or Town, State                                   | Zin C         | nde)                                     |            |
| Š                          | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | П                         | Betty L. Marso   |  |                  |                          | 0                         | •                   |                        |                 |                                  | , ,             | e, Mary  | •             | ,  | Λ          |
| ē,                         | 1 and<br>f Hea<br>item<br>othe  | - 4                       | 20a. Method of Disposition   | -  |                  | ace of Dispos            | sition (Nam               | ne of               |                        |                 | ate                              |                 | Location - City                                  |               |  | 0          |
| 90                         | age ent o   |                           | 1 🖄 Burial 2 □ Cremation 3<br>4 □ Donation 5 □ Other (Spe                | Removal from State                                   | 7                | emetery, crem<br>ne Grov | ,                         | ,                   | · •                    | Ap1             | cil<br>2010                      | Ma              |  |               | Marrila                                  |            |
| Baltimore,                 | mit. F<br>partm<br>porta<br>r inju  |                           | 21. Signature of Funeral Service Lice                                    |  | 1 1 11           | 22.                      | Name and                  | d Addres            | s of Facility          | v Rob           | ert A.                           | Pur             | <u>unt Ai:</u><br>mphrev                         | Fun           | eral H                                   | ome/       |
| ä                          | permir<br>Depar<br>Impor<br>any ir  |                           |  | Talt M   | 100335           | ,                        | Rock                      | vill<br>vill        | e, In                  | ic. 3           | 00 Wes                           | 50-X            | mphrey<br>ontgome<br>2805                        | ery           | Avenue                                   | ·          |
|                            |   |                           | 23a. Part 1. Enter the diseas<br>shock, or heart failure. List only      | mplications that cause                               | d the death      |                          |                           |                     |                        |                 |                                  |                 |  |               | Approximate                              |            |
|                            | Physician/  |                           | Immediate Cause (Final disease or condition                              |  |                  | P-41.                    |                           |                     |                        |                 |                                  |                 |  | - 1           | Interval Betwee<br>Onset and De<br>Weeks |            |
|                            | Medical   |                           | resulting in death)  | a. Respir  | a conseque       | ence of):                | ITE                       |                     |                        |                 |                                  |                 |  | +-            | WEEKS                                    |            |
|                            | Examiner  | ا ـِا                     | Sequentially list conditions,  | b. Perfor  | ated             | Sigmoi                   | d Di                      | vert                | iculi                  | tis             |                                  |                 |  | 5             | Weeks                                    |            |
|                            | D #   | Examiner                  | if any, leading to immediate cause. Enter Underlying                     | Due to (or as  | a consequi       | ands of):                |                           |                     |                        |                 |                                  |                 |  | -1            |  |            |
| 120.                       | scute<br>and<br>trans   | xan                       | Cause (Disease or iinjury that initiated events resulting in death) Last | c  | 2 CODEAGUE       | ance off:                |                           |                     |                        |                 |                                  |                 |  | +             |  |            |
| V '                        | ite be executed<br>hysician and<br>he burial-transit  | dical E                   | resulting in deathy Last   |  | u conseque       | 51100 017.               |                           |                     |                        |                 |                                  |                 |  |               |  |            |
| 200                        | he ye   | ğ                         |  | d  |                  |                          |                           |                     |                        |                 |                                  |                 |  |               |  |            |
| 89                         | ath certifica<br>attending p<br>for use as 1  | Ž                         | IF FEMALE:<br>23b. Was decedent pregnant                                 | 23c. If yes, outcome                                 | of pregnan       | icy                      |                           |                     |                        |                 |                                  |                 | 23d. Date of                                     | المالة المالة |  |            |
| ŏ                          | atter<br>for u  | cial                      | in the past 12 months?   | 1 ☐ Live Birth<br>4 ☐ Pregnant a                     |                  | death 3 a                | Ectopic p                 |                     | /                      |                 |                                  |                 | Month  |               | y<br>Day Yea                             | ar         |
| P.O. Box 687               | Attending Physician: The law requires that the death certifica<br>ar death.  ector: After this certificate has been signed by the attending p<br>by the funeral director, page 2 should be detached for use as t  | Completed by Physician/Me | 9 Unknown  | 9 🗌 Unknown  |                  |                          |                           |                     |                        |                 |                                  |                 |  |               |  |            |
| P.0                        | es that tigned b  | Ϋ́P                       | Part II. Other significant conditions                                    | contributing to death t                              | out not resu     | Iting in the ur          | nderlying c               | ause give           | en in Part I.          |                 | 23e. Did t                       | obacco          | use contribute                                   | e to the      | cause of dea                             | th?        |
| S,                         | uires<br>in sig   | ed t                      |  | Renal_Fa   | ilure            |                          |                           |                     |                        |                 | 1 🗆                              | Yes 2           | 2 🕅 No 3 □                                       | Proba         | ably 4 🗆 Un                              | known      |
| Ö                          | w require<br>s been s<br>2 should   | plet                      |  |  |                  |                          |                           |                     |                        |                 | 24a. Was                         |                 | 24b. Were  | autops        | sy findings ava                          | ailable    |
| 3ec                        | he la<br>te ha<br>vage 2  | E                         |  |  |                  |                          |                           |                     |                        |                 | auto<br>perfo<br>1  Yes          | psy<br>ormed?   | death  | n?            | No                                       | ise oi     |
| a                          | ysician: The law Is certificate has be director, page 2 s   | Be C                      | 25. Was case referred to medical examiner?                               |  |                  |                          |                           | 26. Pla             | ce of Deat             | h (Check        |                                  | 2 = 1           | 40 <u>                                      </u> | 103 2         |  |            |
| ξ                          | Physic<br>this ce<br>al dired   | 2                         | 1 Yes 2 No   | Hospital:<br>1 🛣 Inpat                               | ient 2 🗆 E       | R/Outpatient             | 3 🗆 DC                    | Othe                | r:<br>4 🗌 Nu           | rsing Hor       | ne 5 🗆 Resi                      | dence           | 6 ☐ Other (S)                                    | pecify)       |  |            |
| of                         | ding Ph<br>h.<br>After th<br>funeral  | ite:                      | 27. Manner of Death 1 → Natural 5 → Pending                              | 28a. Date of inju<br>(Month, Da                      | ıry<br>ıy, Year) | 28b. Time of injury      | 28                        | Bc. Injury<br>work? | at                     | 2               | 8d. Describe I                   | how inju        | iry occurred                                     |               |  |            |
| ö                          | tendi<br>death<br>tor: A<br>the fu  | iţi                       | 2 Accident Investigat 3 Suicide 6 Could not                              | he   |                  |                          | М                         | _                   | Yes 2 🗌                | No              |                                  |                 |  |               |  |            |
| Division of Vital Records, | II or Attendir<br>safter death.<br>I Director: Af<br>d in by the fu   | Certificate:              | 4 Homicide determine   |  |                  | ne, farm, stre           | et, factory,              | office              |                        | 2               | 28f. Location (\$<br>City or Tov |                 | nd Number or<br>e)                               | Rural F       | Route Number,                            |            |
|                            | Hospital or<br>24 hours afte<br>Funeral Dir<br>ted filled in  | Sal (                     | 29a. Certifier 1 X Certifying Ph   | and since To the book of                             |                  |                          |                           | la a Aires -        |                        | 10              |                                  |                 |  |               |  |            |
|                            | Hos<br>24 hc<br>Fun<br>eted   | Medical                   | Check 2 Medical Exa  | nysician: To the best of<br>miner: On the basis of e | examination      | and/or investi           | gation, in n              | ny opinior          | n. death occ           | curred at :     | the time, date a                 | and plac        | e, and due to t                                  | he caus       | e(s) and mann                            | er stated. |
|                            | To the Hospital or Atta<br>within 24 hours after de<br>To the Funeral Directa<br>completed filled in by the   |                           | only one) 3 Certiffing No. 29b. Signature and title of certifier         | urse Practioner: To the                              | Dest of The      | ki iowieage, di          |                           | License             |                        | and place       | , and due to th                  |                 | (s) and manner<br>ate signed (Mo                 |               |  |            |
|                            | ->-0  |                           | ) / M  | (  | (1)              |                          |                           |                     | D218                   | 9.8             | 1                                |                 |  |               |  |            |
|                            | ' d   |                           | 30. Name and address of person who                                       | completed cause of                                   | leatif (Item 2   | 23a) (Type, Pr           | int)                      |                     | D210                   | ,,,             |                                  |                 | April_   | 17,           | 2010                                     |            |
|                            | 1   |                           | Ernest D. Hanow  |  |                  |                          |                           | rive                | #40                    | 3, B            | ethesda                          | a, M            | arylan   | d 20          | 0817-18                                  | 342        |
|                            | Stat  | е                         | 31. Date filed (Month, Day, Year)  | 32. Registr  | ar's Signatu     | ire                      |                           |                     |                        |                 |                                  |                 |  |               |  |            |
|                            | Registra  | ir                        | APR 23 2010  | Charges  | A A              | back                     | F. C.                     |                     |                        |                 |                                  |                 |  |               |  |            |

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia /Medic Examin **Funeral Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment mast be rectified at once. No lan Doloces Baltimore, Maryland 21215-0036

For

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

|  | Registrar  | <u>.</u>   | Cei                                 | titicat   | e of L             | Jeath             |             |                                  | Reg. No                 | ·971                                  | 0   | 12                         | 550                  |  |
|--|--|--|-------------------------------------|---|--------------------|-------------------|-------------|----------------------------------|-------------------------|---------------------------------------|---|----------------------------|----------------------|--|
| n  | 1. Decedent's Name (First, Middle, Last)   |  |                                     |   |                    |                   |             | 2. Date of De<br>Month           | eath<br>Da              | y Yea                                 | ar.   | 3. Time o                  | f Death              |  |
| al   | Dolores M. Nolan   |  |                                     | April 21, 2010  |                    |                   |             |                                  |                         |                                       |   | 3:04                       | $P^{M}$              |  |
| er   | 4a. Facility Name (If not institution, give str  | ,  |                                     | 4b. City, Town, or Location of Death 4c. County of        |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
|  | Greater Baltimore  | e Medical C  | enter                               | Towson Balt   |                    |                   |             |                                  |                         | Balti                                 | mor   | e                          |                      |  |
|  | 5. Social Security Number 6. Sex   | 3.7  | rs. last birthday)<br>79 Yrs.       | If Under<br>Months  | 1 Year<br>Days     | If Under<br>Hours |             | 8. Date of Bi<br>Month<br>9/24/1 | rth<br>930 <sup>2</sup> | 1                                     | Count                                       | ace (State try)            | or Foreign           |  |
|  | Usual Residence of Decedent  | X  | 9 115.                              |   |                    |                   |             | 7/24/1                           | 930                     | Ma                                    | гуг   | and                        |                      |  |
|  | 10a. State 10b. County   | 10c.   | City, Town or Lo                    | cation  |                    |                   |             |                                  |                         |                                       | 10  | Od. Inside C               | ity Limits           |  |
| 힏  | Maryland Baltimore   | Ti   | monium                              |   |                    |                   |             |                                  |                         |                                       |   | 1 ☐ Yes                    | 2 No                 |  |
| Je<br>C  | 10e. Street and Number   | 1.1  | MOTTE                               | 10f. Zip  | Code               |                   |             |                                  | 10a. Cit                | izen of What                          | f What Country?                             |                            |                      |  |
|  | 2525 Pot Spring Roa  | d # S423   |                                     | 21093 U.S.A.  |                    |                   |             |                                  |                         |                                       |   | .,,                        |                      |  |
| nera   |  | . Was Decedent Ever in                             | U.S. 13. V                          | Vas Deced   | lent of Hi         | spanic Ori        | igin? (Spe  | cify Yes or No<br>Rican, etc.)   | 0-                      | 14. Race - A                          | merica                                      | an Indian,                 |                      |  |
| ₫  | 1 ☐ Never Married 2 ☐ Married  | Armed Forces?<br>1 ☐ Yes 2 X No                    | 1                                   |   |                    |                   |             | Rican, etc.)                     |                         | Black, W                              | hite, et                                    | tc.                        |                      |  |
| d  | 3 X Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:                     | 1                                   | □Yes 2  | 2X No              | Specify:          |             |                                  |                         | Specify: W                            | nit   | .e                         |                      |  |
| Be Completed by Funeral Director   | 15. Decedent's Educat<br>(Specify only highest grade c   | tion   | 16a. Deced                          | ent's Usua<br>kind of wor                                 | al Occupa          | ation             | t of workir | 20                               | 16b. K                  | ind of Busine                         | ss/Indi                                     | ustry                      |                      |  |
| nple   | Elementary/Secondary (0-12)  | College (1-4or 5+)                                 | life. L                             | OO NOT us   | e retired          | )                 | t Or WOLKII | <i>i</i> g                       |                         |                                       |   |                            |                      |  |
| ပ္ပဲ   |  | 1  | Homem                               | aker  |                    |                   |             |                                  |                         | Home                                  |   |                            |                      |  |
| Be   | 17. Father's Name (First, Middle, Last)  |  |                                     |   |                    |                   |             | (First, Middle                   |                         | Surname)                              |   |                            |                      |  |
| ٩  | Jordan Chiaruttini   |  |                                     |   |                    | Mari              | е ка        | vanaug                           | []                      |                                       |   |                            |                      |  |
|  | 19a. Informant's Name/Relationship (Type   | . Print)   |                                     |   |                    |                   |             |                                  | -                       | or Town, State                        |   | ,                          |                      |  |
|  | Steve Nolan / Son  |  |                                     |   |                    | . Sui             |             |                                  |                         | Maryla                                |   |                            |                      |  |
|  | 20a. Method of Disposition  1XI Burial 2 ☐ Cremation 3 ☐ Ren   |  | . Place of Dispos<br>cemetery, cren | atory or or   | ther place         |                   |             | ate                              |                         | ocation - City                        |   |                            |                      |  |
| 4 Donation 5 Other (Specify) Druld Ridge Cemetery 4/24/2010 Baltimore,   |  |  |                                     |   |                    |                   |             |                                  |                         |                                       |   | _                          |                      |  |
|  | 21. Signature of Funeral Service Licensee  | 11 11  | 22                                  | . Name an   | d Addres           | s of Facilit      | y Ruc       | k Tows                           | on F                    | uneral                                | Но  | me, I                      | nc.                  |  |
|  | I hand   | 1 Level /  | 10.                                 | <u>50 Yo</u>  | <u>rk R</u>        | oad I             | Cowso       | n, Mar                           | y1ano                   | d 21204                               |   |                            |                      |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |                                     |   |                    |                   |             |                                  |                         |                                       |   | Approximat<br>Interval Bet | tween                |  |
| Immediate Cause (Final disease or condition PNUMMI   |  |  |                                     |   |                    |                   |             |                                  |                         |                                       | 1   | Onset and                  | Death                |  |
|  | resulting in death)  Due to (or as a consequence of):  |  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
|  | Sequentially list conditions,  b   |  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
| ine.   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c. |  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
| каш  | Cause (Disease or injury that initiated events resulting in death) Last C.   |  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
| ω<br>Ξ   | Toolaining in doutiny East   | Due to (or as a cons                               | equence of):                        |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
| n/Medical Examiner   | d  | d  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
| Me   | IF FEMALE:   |  |                                     |   |                    |                   |             |                                  |                         |                                       | -   |                            |                      |  |
|  | 23b. Was decedent pregnant in the past 12 months?  | . If yes, outcome of preg<br>1 ☐ Live birth 2 ☐ Fe | etal death 3                        | death 3 Ectopic pregnancy                                 |                    |                   |             |                                  |                         | 23d. Date of delivery  Month Day Year |   |                            | Year                 |  |
| Physicia   | 1 □ Yes 2 □No<br>9 □ Unknown   | 4 ☐ Pregnant at time of 9 ☐ Unknown                | of death 5 L                        | Other (sp   | ecify)             |                   |             |                                  |                         |                                       |   | Day Year                   |                      |  |
| ٦<br>۲   | Part II. Other significant conditions contril  | buting to death but not n                          | esulting in the un                  | ng in the underlying cause given in Part I. 23e. Did toba |                    |                   |             |                                  |                         |                                       | pacco use contribute to the cause of death? |                            |                      |  |
| ٥  |  | J  | g uno un                            | ,y ot   | 91+C               | sait li           |             | 1 🗆                              |                         | /                                     |   | ably 4                     |                      |  |
| Completed by   |  |  |                                     |   |                    | -                 |             |                                  |                         |                                       |   |                            |                      |  |
| ᇛ  |  |  |                                     |   |                    |                   |             | 24a. Was<br>auto                 | psy                     | prior                                 | to com                                      | sy findings                | available<br>ause of |  |
| ริ   |  |  |                                     |   |                    |                   |             | 1 □ Yes                          | 2 No                    | death<br>1 □ Y                        |   | 2 <b>(2</b> No             |                      |  |
| å<br>Re  | 25. Was case referred to medical examiner?   | pital:   |                                     |   | 045-               |                   | of Death    | (Check only                      | one)                    |                                       |   |                            |                      |  |
| <u> </u>   | 1 les 2 la 140   | 1 Inpatient 2                                      |                                     |   |                    | 4 L. Nu           |             |                                  |                         | 6 ☐ Other (S                          | pecify)                                     | )                          |                      |  |
| <u> </u>   | 1 Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day, Year)          | 28b. Time of<br>Injury              | - 1   | Bc. Injury<br>Work | ?                 |             | 8d. Describe                     | how injur               | y occurred                            |   |                            |                      |  |
| <u>cat</u>   | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  |  |                                     | M   |                    | ′es 2 🗆 I         |             | _                                |                         |                                       |   |                            |                      |  |
| 4 Homicide  5 Hours and Number or Rural Route  City or Town, State)  4 Homicide  5 Hours and Number or Rural Route  City or Town, State)  4 Homicide  4 Homicide  5 Hours and Number or Rural Route  City or Town, State)  4 Homicide  5 Hours and Number or Rural Route  City or Town, State)  4 Homicide  5 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City or Town, State)  6 Hours and Number or Rural Route  City |  |  |                                     |   |                    |                   |             | nd Number or<br>)                | Rural                   | Route Nun                             | nber,                                       |                            |                      |  |
|  |  |  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
|  |  |  |                                     |   |                    |                   |             | as sta                           | ated.<br>the cause(s    | s)                                    |   |                            |                      |  |
|  |  |  |                                     |   |                    |                   |             | lav Vearl                        |                         |                                       |   |                            |                      |  |
|  |  |  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
|  |  |  |                                     |   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
|  | 30. Name and address of person who comp  |  | em 23a) (Type, F<br>6701            | rint)   | 10/1               | 10.5.5            | TB          | altra                            | 101                     | p Mi                                  | 9   | 2170                       | 140                  |  |
|  | 31. Date filed (Month. Day. Year)  | 32/Registrar's Sig                                 |                                     |   |                    |                   | 1 2000      | -111-0                           |                         | , ,                                   |   | -, -0                      |                      |  |
|  | 31. Date filed (Month Day, Year) APR 23 7610   | ozar registrar s sig                               | A. Ja                               | Med !   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |
|  | AT IT W & LUTU   | Market Comment                                     | 10. 190                             | -   |                    |                   |             |                                  |                         |                                       |   |                            |                      |  |

Stat Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |   |                   | State of Maryland / Department of Health and I state Amend Item 25 per me, g902,04/22/2010dhb Certificate of Death   | Mental Hygiei<br>Reg.                           | ne<br>No. 2 0 1 0                             | 12659   |
|----------------------------|---|-------------------|--|---|---|---|
|                            | Physici   |                   | 1. Decedent's Name (First, Middle, Last)  (Porge folk  | 2. Date of Death<br>Month                       | Day Year 8 2010                               | 3. Time of Death 4:40A M                                |
|                            | /Medi<br>Examir<br>Funeral  |                   | 4a. Facility Name (If not institution, give street and number)  4b. Gity, Town, or Location of Death  4b. Gity, Town, or Location of Death  4b. Gity, Town, or Location of Death  4c. Can Aa   8 TOW  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   | un  | 8c/fin  | 0 / Collace (State or Foreign                           |
|                            | Director  |                   | Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  | 8. Date of Birth (Month, Day, Ye. 3-9-)         |   | Od. Inside City Limits                                  |
|                            | r 28a-f sho   | Director          | MD Baltimore Pikesville  10e. Street and Number  10f. Zip Code   | 10g.  | Citizen of What Cour                          | 1 ☐ Yes 2 ☑ No  |
|                            | ath witi  | ralD              | 3800 Old Court Rd 230 21208  |   | USA   |   |
| 9800                       | be filed within 72 hours after death with the Maryland<br>ntal Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examirer must be redified at | by Funeral I      | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban Mexican, Puert If Yes, Give Year or Dates:   | pecify Yes or No-<br>o Rican, etc.)             | 14. Race - Americ<br>Black, White,            |   |
| 21215-0036                 | I within 72 ho<br>giene.<br>r than "natu<br>re Medical  | Completed         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)  (in 1) STC  | king 16b.                                       | Kind of Business/In                           | dustry<br>A   |
| Maryland 2                 | Mer<br>Mer<br>arke  | To Be C           | 17. Father's Name (First, Middle, Last)  18. Mother's Nam  18. Mother's Nam  18. Mother's Nam  | ne (First, Middle, Maid                         | Ison  |   |
| e,                         | 1 and 2 s<br>Health ar<br>em 27 is<br>ther trau   |                   | 19a. Informan's Name/Relationship (Type. rint)  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory on other place)   | . Mount   | ain View)<br>Location - City or To            | CA94043   |
| Baltimor                   | permit. Pages<br>Department of<br>Important: If it<br>any Injury or o   |                   | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Wess of Facility (a)   | 8-2010 K  |   | eral service  |
|                            | ΔD = 6 0;   |                   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac  | or respiratory arrest                           | da 11stong                                    | MD 21/33 Approximate                                    |
| -                          | Physician<br>/Medical   |                   | shock, or Meart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Thracerebra Hemorrhage  Due to (or as a consequence of):  |   |   | Interval Between<br>Onset and Death                     |
|                            | Examiner  | Examiner          | Sequentially list conditions, if any, leading to mine the cause. Enter Underlying Cause (Disease or injury   | 11  |   |   |
| 68760,                     | icate be executed<br>physician and<br>s the burial-transit  | edical Exa        | that initiated events resulting in death) Last C. Due to (or as a consequence of):  d. CERTIFICATION APPROXIMATION CERTIFICATION | WED BY MEDICAL EXAM                             | IINER   |   |
| O. Box 6                   | eath certifi<br>attending<br>for use as   | Physician/Med     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown  |   | 23d. Date of delive                           | ery<br>Day Year   |
| ords, P.                   | law requires that the de<br>as been signed by the<br>2 should be detached   | by                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | co use contribute to the                      | ne cause of death?                                      |
| Division of Vital Records, | in: The law rificate has be<br>or, page 2 shi   | Completed         | 25. Was case referred to medical   | 24a. Was an autopsy performed'                  | prior to co<br>death?                         | psy findings available<br>mpletion of cause of<br>2  No |
| Ę <                        | nysicia<br>iis cert<br>directo  | o Be              | examiner? Hospital: Other:   | th <i>(Check only one)</i><br>ome 5 ☐ Residence | 6 Other (Special                              | (v)   |
| sion o                     | ending Pt<br>sath.<br>or: After th<br>he funeral  | Certification: To | 27. Manns of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident   28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury at Work?  1 Yes 2 No   | 28d. Describe how in                            | <del> </del>                                  |   |
| Divi                       | To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page |                   | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a, Certifier  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place   | 28f. Location (Street<br>City or Town, St       | ate)  |   |
|                            | he Hos<br>n 24 hc<br>he Fun<br>pletely  | Medical           | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the basis of examination and of the basis of examination | rred at the time, date                          | e(s) and manner as s<br>and place, and due to | stated.<br>the cause(s)                                 |
|                            | Vithi<br>Com  | Ž                 | 29b. Signature and title of certifier 29c. License number  |   | Date signed (Month,                           |   |
|                            | 10  | )                 | 30. Name and a days of person who completed cause of death (Item 23a) (Type, Print)  |   | 2141  | N   |
|                            | Sta   |                   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N.S. Rajupakse, M.D. 2835 Sinjth AV, Suite 203 Baltin.  31. Date filed (Month, Day, Year)  APR 22 2010 Section 8. Aparts   | TOUTE / TOLD &                                  |   |   |
|                            | Registr   | ar                | APR 2 2 2010 Sente B. gare   |   |   |   |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM# 20a, perFH, G902, 4/27/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, MIUO) Pitz, Sr. Frederick C. Pitz, Sr. Day Month 21, April 2010 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b, City, Town, or Location of Death Baltimore Ivy Hall Nursing Home
5. Social Security Number 6. Sex 7. A Middle River 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F 90 12/23/1919 MD 212-09-1288 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Virginia Beach VA 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23451 USA 205 34th St. Apt. 812 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWJL 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronics Tester Manufacturing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk George Frederick Pitz Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23451 19a. Informant's Name/Relationship (Type. Print) 205 34th St. Apt. 812 Virginia Beach, VA Frederick Pitz, Jr./Son 20a. Method of Disposition
1 Burial 2 SGremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 26, Gardens of Faith Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility AFA/Stephen D.Lohrmann 21. Signature of Funeral Service License MO1585 P.A. Rebecca sackemon 8717 Green Pastures Dr. Balto, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): PIRATION Sequentially fist conuncins, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MALNUTRIFION Due to (or as a consequence of) EMENTIA IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown OSTEOPORUSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Tyes 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 👱 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

the Hospital or Attending

death.

within 24 hours after death To the Funeral Director completely filled in by the

**Physician** 

/Medical

Examiner

Director

Funeral

\$

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

1 and 2 should be filed within Health and Mental Hygiene.

Item 27 other tra

permit. Pages 1
Department of Hi
Important: If Iter
any injury or oth

Physician

/Medical

Examiner

physician and s the burial-trans

attending p as

signed by t d be detach

certificate

After this c

P.O. Box 68760,₹

Division or Vital Records,

Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

3altimore, Maryland 21215-0036

Registrar

of person who completed cause of death (Item 23a) (Type, Print)
UR JUKE 2 Market Place Dundalk MD 21222 82. Registrar's Signature

indu a Talle M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2<u>010</u> April Laura Virginia Phares 17 РМ 3:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 Months Days Hours Min 212-24-0663  $Ju^{(Month}_{V}18^{py, Year}_{V}1929$ Director 80 Mary land Usual Residence of Decedent 3a or 28a-f show be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2X No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13302 Justice Road 20853 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 🙀 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Stock Clerk Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Richard Hager Myrtle Nixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Phares/ son 9505 Queens Guard Court, Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 🛛 Cremation 3 Demoval from State cemetery, crematory or other place, Important: If any injury or April Montgomery Crematorium 15, 4 Donation 5 Other (Specify) 2010 Firm, Inc. 19, 2010 | Bethesda, Maryla 22 Name and Address of Facility Robert A. Pumphrey Funeral ROCKVIIIe, Inc. 300 West Montgomery Avenue Maryland uneral Home/ Signature of Funeral Service Licenses 19 M01498 Rockville. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of, been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 X No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate performed? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6X Other (Specify) Hospital: Other: မ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of

31. Date filed (Mon hop)

Eliezer Soto, M.D.

OKYSIUan

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year) April 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per Fh 8902 4/23/10 TT
State of Maryland? Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day APRIL 20, 2010 11:18**Physician** PET0K THEODORE M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE 1799 E. JEFFERSON STREET, #121 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Y 4/4/1917 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 180 M 2□ F Days Min. Months **Funeral** 93 349-05-6962 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Hyglene. sther than "natural", or Items 23a or 28a-f show 10a. State 10b. County 1 ☐ Yes 2 X No ? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar mat be redified ROCKVILLE Director MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20852 JEFFERSON STREET, #121 1799 E. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WHITE 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 ģ 3 Nidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FILM ANIMATED FILM PRODUCER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JENNY Jennie 2 should be fill and Mental F WEINGARDEN **PETOK** HARRY ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5608 GREENSPRING AVENUE, BALTIMORE, MD 21209 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau BILL PETOK/SON 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 NBurial 2 Cremation 3 NBemoval from State 4/22/2010 LIVONIA, MI BETH EL MEMORIAL PK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral Service Dcenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical **HYPERTENSION Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine DIABETES MELLITUS TYPE II Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, HYPERLIPIDEMIA by Physician/Medical 23d. Date of delivery IF FEMALE: Year 23b Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown HYPOTHYROID Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COGNITIVE IMPAIRMENT autopsy performed? Yes 2 No 2 □No 1 TYes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospital: 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death after death. 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 ☐ Suicide 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e Funeral 1 Medical within 24 hor To the Fune completely f (Check only one) 29d. Date signed (Month, Day, Year) the 29c. License number 29b. Signature and title of certifier 2010 20 DODS JEEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSE ROAD, ROCKVILLE, MD 20852 DAMIEN J. DOYLE, M.D. Registrar's Sign 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |                  | 1- For Amend Item 25 per me   | Maryland (Pep<br>Cer  | artment of b<br>tificate of b                                 | lealth and<br>Death   |   | iene  | 12663  |  |
|----------------------------|--|------------------|---|---|---|---|---|---|--|--|
|                            | Physici<br>/Medi   | al               | 1. Decedent's Name (First, Middle, Last)  A. Facility Name (If not institution, give street and number)   |   | bers<br>14b. City, Town, o                                    | Location of Deat  | 2. Date of Deat                                       | Day Year Of 2010                                | 3. Time of Death                                   |  |
| 1                          | Examir<br>Funeral<br>Director  | ier              | The Johns Hopkins Hospital  | Age (In yrs. last birthday) $57 \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad \qquad$ | Baltimore  If Under 1 Year  Months Days                       |   | S 8. Date of Birth                                    | Year) 9. Birth                                  | nplace (State or Foreign                           |  |
|                            | TO TO  | ctor             | Usual Residence of Decedent 10a. State 10b. County Virginia   | 10c. City, Town or Lo   |   |   | pan. 10   | , 1953  Car                                     | olina  10d. Inside City Limits  1 XYes 2 □ No      |  |
|                            | eath with th   | Funeral Director | 10e. Street and Number  5444 Stoneybrook Drive  11. Marital Status 12. Was Deceden  |   | 10f. Zip-Code<br>2 4 0 1 8                                    | ispanic Origin? (S  |   | U.S.A.  14. Race - Amer                         |  |  |
| 9000                       | hours after d<br>ural", or iten<br>I Examiner r  | by               | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:   | X No  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🛣 No   | Specify:  |   | Black, White                                    | etc.<br>ite  |  |
| 21215-0036                 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>other than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at | Completed        | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 1)  | (Give<br>life. L  | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of wo<br>Health<br>dinato                                   | Care  | Charitab<br>Foundati                            | le   |  |
| Maryland                   | 2 should be fill and Mental His marked oth aumatic event   | To Be            | 17. Father's Name (First, Middle, Last)  Russell Lawson Cline  19a. Informant's Name/Relationship (Type. Print)   | 19b. Mailir   | ng Address (Street  | Geral   | me (First, Middle, I<br>dine Hai<br>ural Route Number | ,   | p Code) 2 4 0 1 9                                  |  |
| nore, Ma                   | ss 1 and 2<br>of Health a<br>item 27 is<br>other trai  |                  | Glen N. Roberson/Husba 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  | and 5444<br>20b. Place of Dispo   | Stoneyk<br>sition (Name of<br>natory or other place           | prook Di  | rive,SW,  | Roanoke,  | Virginia<br>own, State                             |  |
| Baltimore,                 | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                  | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  Mulial Maryello  23a. Part 1. Enter the disease, or complications that cause   | 60  | Name and Addre  | <sup>ss of Facility</sup> Ma<br>ord Road                                | arzullo<br>d,Baltin                                   | nore, Mary                                      | Chapel,P.A<br>land21214                            |  |
| )                          | Physician<br>/Medical<br>Examiner  | _                | shock, or heart failure. List only one cause on each li   | +RACENEB  |   | morrho  | ig l  |   | Approximate<br>Interval Between<br>Onset and Death |  |
| ,092                       | certificate be executed ding physician and use as the burial-transit   | dical Examiner   | it any locating 1 mms lists.  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to for an or | SHALL BY WE   | DIGHT EXAMINER  |   |   |   |  |  |
| O. Box 68                  | death certific   | Physician/Me     |   | 2 Fetal death 3   | Ectopic pregnance   | ,   |   | 23d. Date of delivery<br>Month Day Year         |  |  |
| ords, P.                   | The law requires that the de<br>te has been signed by the a<br>page 2 should be detached   | þ                | Part II. Other significant conditions contributing to death   | but not resulting in the u  | nderlying cause gi  | ven in Part I.  | 23e. Did tob  | eacco use contribute to                         |  |  |
| tal Rec                    | The lavate has   | e Completed      | 25. Was case referred to medical  |   |   | 26 Place of Dog   | 24a. Was an autopsy perform 1 Tyes 2                  | prior to death? No 1 Yes                        | opsy findings available ompletion of cause of      |  |
| Division of Vital Records, | ing Phy<br>I.<br>After this<br>funeral o   | To B             | examiner?   | ient 2 ER/Outpatient<br>ury 28b. Time of<br>Injury  | 28c. Injun<br>Work  | er: 4  Nursing H  |   | nce 6 🗆 Other (Speci                            | (y)  |  |
| DIVISI                     | e Hospital or Attendii 124 hours after death. e Funeral Director. Afeletely filled in by the fu  | Certification:   | 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of in building, e  | jury - At home, farm, stre<br>tc. (Specify)   | eet, factory, office  | t, factory, office  28f. Location (Street and N<br>City or Town, State) |   |   |  |  |
|                            | To the Hosp<br>within 24 hor<br>To the Fune<br>completely fi   | edica            | 29a. Certifier (check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner services.  29b. Signature and title of certifier  | of examination and/or inv   | restigation, in my o  | pinion, death occi  | urred at the time, d                                  | ause(s) and manner as<br>ate and place, and due | to the cause(s)                                    |  |
|                            | ,  |                  | 30. Name and address of person who completed cause of   |   | RES   | o do  |   | April 9,  |  |  |
|                            | Star<br>Registra   | ie<br>ar         | Josh L. Duckwor<br>31. Date filed (Month, Day, Year)<br>APR 2 2 2010  | th, mo  | W   | 600   | North Wolf  | ie St, Baltimo                                  | re, MD, 21287                                      |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ . 2<u>010</u> 22 Robison 4:20 A M Medical <u>Evelyn</u> Virginia 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 409 Enfield Road Joppa Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr. 26, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F 1920 Delaware **Director** 89 221-05-4070 Usual Residence of Decedent ifiled within 72 hours and talk Hygiene.
ed other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 409 Enfield Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black. White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify: Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental File is marked of George (unk) Hazel Hazel (unk) Wix and 2 should be Health and Meter 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr <u>Bernard Robison / Husband</u> 409 Enfield Road, Joppa, Maryland 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Service Corp.: 4-23-10 Towson, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Fiver the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Or set and leath Immediate Cause (Final Physician/ ENAL ay disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner me Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a con equence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be RTENSION Records, 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 4POTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 🛛 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? after death. 2 Accident Investigation 1 🗌 Yes 2 🗌 No the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature)and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ex MI . Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.0.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:45 ean pril /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Glade Valley Nursing & Rehab. Walkersville
If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1 ☐ M 2 🔀 F Yrs. 103-14-9991 Director 12-27-1923 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 XYes 2 No Funeral Director MD Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6441 Jefferson Pike, #221 21703 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by 3 XVidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Community College permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Importent: If item 27 is marked other till eny injury or other treumatic event, IIIM 2005. 12 Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Fabel Annie Tarrent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1888 Roster Dr., Marriottsville, MD 21104 Richard L. Rapp - Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 4-22-10 Woodbine, MD Journey Crem 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arter Pnysician /Medical nce of): Examiner enterie + Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit be tersion Due to as a consequence of) Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ementia 1 Yes 2 No 3 Probably 4 Donknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1∐ Yes 2√ZNo Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident i Director: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier - 005 4636 ADRIL 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Montclaire Ave, Frederick, MD Hague 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a & 28d, per ME g903 5/12/10 TT

State of Maryland / Department of Health and Mental Hygiene

State Amend Item 28b per me,g902,04/23/2010dhb

Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $201 \breve{0}^{\text{ear}}$ Physician/ April 21 Day Рм Lawrence Riedman 4:16 Medical 4a. Facility Name (if not institution, give street and ηumber) Examiner 4b. City, Town, or Cocation of Seath 4c. County of Death mon 6009 Soot tip SM 20 mes 6 8. Date of Birth (Month, Day, Year) Tanuary 5, 1 5. Social Security Number 6. Sex 1 X M 2 □ F If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav **Funeral** Months Davs Hours Min. Country) Director 165-38-1938 1949 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Bethesda 1∩e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6009 Southport Drive 20814 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White "natural", 3 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Lawyer Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lawrence A. Riedman Mary Anne Zugay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Mintz / Wife 6009 Southport Drive, Bethesda, Maryland  $2081\underline{4}$ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aprilate23, metery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 2010 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. ₩01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23d-Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Suffocation complicated by narcotic and Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Zolpidem intoxication Medical Due to (or as a confequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, the burlal-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 1 Yes Completed completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred subject took 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: Unknown 1 Natural 5 Pending 1 🗌 Yes 2 🗖 No \$5 21 2010 irugs & put bag over head Accident Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 709 5 5 7 7 4 Homicide determined 110006 Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo ome 210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER mo omE Day 0902 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#19a, per INF, G902, 4727/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Ann Sickler Pay, Abril 27010 2:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7336 Chesapeke Rd. Middle River Baltimore . Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country)MD Days 1 □ M 2 🕶 F Hours 212-26-9931 79 167/26/1930 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7336 Chesapeake Rd. 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u> Home Maker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Robert Fisher -Unk-19a. Informant's Hame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Raiser/Daughter 135 Ventnor Terr. Dundalk, MD 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 2010 Beltsville. MD 21. Signature of Funeral Service Licensee 401585 22. Name and Address of Facilit CAFA/Stephen D.Lohrmann P.A. Robecca 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHEROSC LEROTIC CAMPIO VASCULTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for sels consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 2 No Yes 2 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes 은 Within 24 hours after death,

To the Funeral Director. After this of the Funeral Director. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier marchen D0060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 Ry # 208 KHETERIAL PHIL POPELPHIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 23/0 Physician/ Month OFOOPM Medical 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death omerse ltimore last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 6 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21202 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed, life DO NOT use retired, Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) မ Monroe mant's Name/Relationship (Type Number, City or Town, State, Zip Code, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremator Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify, 21. Sig at re of Fune al ervice Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day ☐ Pregnant ☐ Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ # 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital 2 No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2  $\square$  No Accident Investigation within 24 hours after deat To the Funeral Director. 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signa 29d. Date signed (Month. Day, Year) 88 was address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 23 State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |  |                  | <b>1 –</b> For<br>State<br>Registrar  | State of Ma   | aryland                           |                          | artment of F  | -                              | •                                    | giene<br>Reg. No. | 2010                                 | 12669   |
|--|--|------------------|---|---|-----------------------------------|--------------------------|---|--------------------------------|--------------------------------------|-------------------|--------------------------------------|---|
|  | Dharist  |                  | 1. Decedent's Name (First, Middle, Last   | )   |                                   |                          |   |                                | 2. Date of De                        | ath<br>Day        | Year                                 | 3. Time of Death                                  |
|  | Physici<br>/Medic  |                  | James W.  | Schmidt   |                                   |                          |   |                                | April                                | 1                 |                                      | 09:32 P <sup>M</sup>                              |
| -desor.  | Examin   |                  | 4a. Facility Name (If not institution, give   | street and number)  |                                   |                          | 4b. City, Town, o   | Location of Death              | 1                                    | 4c.               | County of Death                      |   |
| x2   |  |                  | 8050 Maywood Aver   |   |                                   |                          |   | asadena                        |                                      |                   | Anne Ar                              |   |
|  | Funeral  |                  | 5. Social Security Number 6. Se   | x 7.Ago<br>MIM 2□F  |                                   | nst birthday)<br>79 Yrs. | If Under 1 Year<br>Months Days                                | If Under 24 Hrs.<br>Hours Min. | (Month, Da                           | y, Year)          | Coun                                 | lace (State or Foreign<br>try)                    |
|  | Director   |                  | Usual Residence of Decedent   |   |                                   | /9 113.                  |   |                                | March                                | 29 1              | .931                                 | MD  |
|  | land<br>ow   |                  | 10a. State 10b. County  |   | 10c. City,                        | Town or Lo               | cation  |                                |                                      |                   | 10                                   | 0d. Inside City Limits                            |
|  | Mary<br>Fr sh  | ট্               | Maryland Anne Ar  | undel   |                                   |                          |   | Pasaden                        | a                                    |                   |                                      | 1 ☐ Yes 2 反 No                                    |
|  | r 28¢  | Director         | 10e. Street and Number  |   |                                   |                          | 10f. Zip Code   | - abaccin                      |                                      | 10g. Citi         | zen of What Coun                     | try?  |
|  | h wit  |                  | 8050 Maywood Aver   | nue   |                                   |                          |   | 21122                          |                                      |                   | USA                                  |   |
|  | ems<br>ems   | Funeral          | 11. Marital Status  | 12. Was Decedent I<br>Armed Forces?                                     | ver in U.S                        | . 13. \                  | Was Decedent of H   | ispanic Origin? (S             | pecify Yes or No                     |                   | 14. Race - Americ<br>Black, White, e |   |
| 36   | or it  |                  | 1 Never Married 2 Married   | 1 ∏Yes 2 □ N<br>If Yes, Give  | lo                                |                          | . ree, opeany east  | Specify:                       | o 1 110di 1, 010.)                   |                   |                                      | ite   |
| ö  | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examinar must be notified at  | d by             | 3 ☐ Widowed 4 ☒ Divorced  | Year or Dates:  |                                   |                          |   |                                |                                      |                   |                                      |   |
| 5  | "nat   | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e co <i>mpleted)</i>  |                                   | 16a. Deced               | tent's Usual Occup<br>kind of work done<br>DO NOT use retired | ation<br>during most of wor    | king                                 |                   | nd of Business/Inc                   | lustry  |
| 12   | withii<br>ene.<br>than   | Ĕ                | Elementary/Secondary (0-12)   | College (1-4or 5  | +)                                | me. L                    | Moulder   | 1)                             |                                      |                   | ectrical<br>ufacturi:                |   |
| 0  | filed<br>Hyg<br>Sther<br>ent, I  |                  | 17. Father's Name (First, Middle, Last)   |   |                                   |                          | Mouraer   | 18. Mother's Nan               | ne (First, Middle,                   |                   |                                      | 19  |
| au   | buld be f<br>Mental<br>arked o   | To Be            | Joseph Schmi  | .dt   |                                   |                          |   | Marie                          | Spi                                  | ndle              | r                                    |   |
| Maryland 21215-0036  | should<br>and Mer<br>marke<br>umatic   | -                | 19a. Informant's Name/Relationship (Ty  | pe. Print)  |                                   | 19b. Mailin              | ig Address (Street  | and Number or Ru               | ral Route Numbe                      | er, City or       | Town, State, Zip                     | Code)   |
| Š  | and 2<br>ealth a<br>n 27 is  |                  | James R. Schmidt  | (son)   | 100                               | <br>  32 д               | ohnson Ro   | nad Pasa                       | dena Mi                              | 7 27              | 122                                  |   |
| e G  | item   |                  | 20a. Method of Disposition  |   | 20b. Pla                          | ace of Dispo             | sition (Name of<br>natory or other place                      | (a)                            | Date                                 |                   | cation - City or To                  | wn, State   |
| Ĕ  | Pages<br>nent of<br>ant: If its<br>ary or o  |                  | 1 ☐ Burial 2 ☑ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  |   |                                   |                          | ematory I   |                                | $\frac{1}{010}^{26}$                 | Balt              | imore, M                             | arvland   |
| Baltimore,   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examples must be notified at once. |                  | 21. Signature of Funeral Service Licens   | ee \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \                                  |                                   | 22                       | . Name and Addre  | ss of Facility                 |                                      |                   |                                      | ome, P.A.   |
| m<br>—   | 89 E 8 9   |                  | Muschell  | Stall   | حميا                              | Dele                     | 3111 Moi  | ıntain Ro                      | ad, Pasa                             | adena             | a, MD 21]                            | L22   |
| and the same of th | Physician  |                  | 23a. Part 1. Anter the disease, or compl<br>shock, or heart failure. List only or<br>Immediate Cause (Final<br>disease or condition | ne cause on each lir  | e.                                | Donot ente               |   | ig, such as cardiac            | or respiratory a                     | rrest,            |                                      | Approximate Interval Between Onset and Death      |
|  | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as   | a conseque                        | ence of):                |   |                                |                                      |                   |                                      |   |
|  | _xammo   | <u>.</u>         | Sequentially list conditions,   | EMA   | mys                               | Em                       | •   |                                |                                      |                   |                                      | 10 ham  |
| ^  | nsit   | nin              | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury  | Table to for de a   | t dontseque                       | инан оту                 |   |                                |                                      |                   |                                      |   |
| 8760kg   | cate be executed<br>physician and<br>the burial-transit  | Examiner         | that initiated events resulting in death) Last  | Due to (or as   | a conseque                        | ence of):                |   |                                |                                      |                   |                                      | . <u>.</u>  |
| 760  | e be siciar  | dical E          |   |   |                                   |                          |   |                                |                                      |                   |                                      |   |
| 89   | ifficate<br>g phys   | edic             |   |   |                                   |                          |   |                                |                                      |                   |                                      |   |
| O. Box   | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit   | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown | 2 🗌 Fetal o                       | death 3                  | Ectopic pregnanc Other (specify)                              | у                              |                                      | 2                 | 3d. Date of delive                   | ry<br>Day Year                                    |
| <u>7.</u>  | that the de<br>ned by the<br>detached  |                  | Part II. Other significant conditions con   | ntributing to death by  | t not result                      | ting in the ur           | iderlying cause glv   | en in Part I.                  | 23e. Did to                          | obacco III        | se contribute to th                  | e cause of death?                                 |
| Vital Records,   | w requires to been signer should be of   | ted by           |   |   |                                   |                          |   |                                | 1)(1)                                |                   |                                      | ably 4 ☐ Unknown                                  |
| r  | The ate h  | Completed        |   |   |                                   | -                        |   |                                | 24a. Was<br>autop<br>perfo<br>1 □Yes |                   | prior to cor<br>death?               | osy findings avallable inpletion of cause of 2 No |
| <u>=</u>   | ician: The<br>certificate<br>rector, pag   | Be C             | 25. Was case referred to medical examiner?  |   |                                   |                          |   | 26. Place of Dea               |                                      |                   | 1 - 1 - 1 - 1                        | 2 2 110   |
| 5  | hysik<br>this o  |                  | 1 ☐ Yes 2 X No  |   |                                   | R/Outpatien              | t 3 □ DOA Oth   | er: 4 Nursing H                | ome 5 Resid                          | dence 6           | ☐Other (Specif)                      | <i>(</i> )  |
| ַ  | ing P  | ü                | 27. Manner of Death  1 Natural 5 □ Pending  | 28a. Date of Injur<br>(Month, Day                                       | y<br>; Year)                      | 28b. Time of<br>Injury   | 28c. Injur<br>Worl  | y at<br>(?                     | 28d. Describe h                      | now injury        | occurred                             |   |
| <u>s</u>   | tend<br>leath.<br>tor: /<br>the fi   | cati             | 2 Accident investigation 3 Suicide 6 Could not be   |   | 40                                |                          |   | Yes 2 □No                      | -                                    |                   |                                      |   |
| DIVISION   | or Al  | ertification: To | 4 ☐ Homicide determined   | 28e. Place of Inju<br>building, etc                                     | ry - At hom<br>. <i>(Specify)</i> | ne, tarm, stre           | et, factory, office   |                                | 28f. Location (S<br>City or Tou      |                   | d Number or Rura                     | l Route Number,                                   |
|  | pital<br>ours a<br>eral i  | O                | 29a. Certifier 1 Certifying Phys  | sician: To the heat o   | if my know                        | ladae daeth              | occurred at the time  | ne date and place              | and due to the                       | 001100/51         | and manner es -                      | totad   |
|  | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I  | edical           | (Check only one)  | ner: On the basis of<br>and manner sta                                  | examination                       | on and/or in             | estigation, in my c   | pinion, death occu             | rred at the time,                    | date and          | place, and due to                    | the cause(s)                                      |
|  | To the<br>within<br>То the   | Me               | 29b. Signature and title of certifier   |   |                                   |                          | 29c. Licens   | e number                       |                                      | 29d. Date         | e signed (Month, L                   | Day, Year)  |
|  | ,,,,   |                  | Pranu 1   | iten  | r                                 | MD                       | D3  | 2111                           |                                      | 41:               | 20/10                                |   |
|  | 141  |                  | 30. Name and address of person who co   | mpleted cause of de   | eath (Item 2                      | 23a) (Type, I            |   | , , , ,                        |                                      | 1/                | /.                                   | 4   |

State Registrar

3001 S. HAMOVERST BALD'More MD 21225 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last. 2. Date of Death 3. Time of Death Year **Physician** 1 SKILLMAN OSEPH 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) LOCH RAVEN 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore and Rehabilitation VA Community 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 183-14-3048 84 1925 Director Jun 11. Pennsylvania Usual Residence of Decedent 10h County 10a State 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examination must be nothed at Baltimore Director Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 21 Cody Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ If Yes, Give 43-47 Year or Dates: 1 ☐Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Linotype Operator Printing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othany or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Skillman Francis Margaret ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Joseph E. Skillman, Jr.-son 21 Cody Ave., Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 4/22/10 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 1050 York Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic STIZUCTIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to mineriate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autonsy certificate 1 □ Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

3900 LOCH RAVEN

29d. Date signed (Month. Day, Year)

and manner stated.

HEITER 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

|                            |   |                  | For State Registrar   | State of Mary  | land / Depa                         |   | lealth and I                                 | Mental Hyg  | _                                    | libie.                      | 1267   |
|----------------------------|---|------------------|---|--|-------------------------------------|---|--|---|--------------------------------------|-----------------------------|--|
|                            | Physici   | an/              | 1. Decedent's Name (First, Middle, Last)  | noloin   |                                     |   |  | 2. Date of Deat<br>Month                          | th<br>Day                            | Year                        | 3. Time of Death                                   |
| d                          | Medi<br>Exami   |                  | James L. S1  4a. Facility Name (if not institution, give si  SAINT JOSEPH IN  |  | NTER                                |   | r Location of Death                          |   | 4c. County                           |                             | MORE   |
|                            | Funeral<br>Director   |                  | Social Security Number 6. Sex   |  | vrs. last birthday)<br>Yrs.         | If Under 1 Year Months Days                                     | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth<br>(Month, Day,<br>Sept. 19      |                                      |                             | lace (State or Foreign                             |
|                            | f show  | tor              | Usual Residence of Decedent 10a. State 10b. County  | ı  | . City, Town or Lo                  |   |  | 10000111  | , = 0 = 0                            |                             | Od. Inside City Limits                             |
|                            | th with the Maryland<br>ms 23a or 28a-f sho<br>must be notified at  | Funeral Director | Florida Indian R  |  | Vero B                              | each<br>10f. Zip Code<br>32963                                  |  | 1   | 10g. Citizen of V                    |                             | 1 ☐ Yes 2 No<br>ry?                                |
| 36                         | er dea<br>or itel<br>miner  | 含                | 9220 Autumn Cour  11. Marital Status  1  Never Married 2  Married  3  Nover Married 4  Divorced   | 2. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No   |                                     | Was Decedent of H f Yes, specify Cuba                           | ispanic Origin? (Sp<br>n, Mexican, Puerto    | ecify Yes or No-<br>Rican, etc.)                  |                                      | e - America<br>k, White, et | tc.  |
| Maryland 21215-0036        | in 72 hours aft<br>e.<br>nan "natural",<br>: Medical Exal   | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  | Year or Dates. 1:  | (Give i                             | lent's Usual Occup<br>kind of work done o<br>O NOT use retired) | luring most of work                          | iing  | 16b. Kind of Bu                      | ısiness Inde                | -  |
| and 21                     | ge 1 and 2 should be filed within 72 hour<br>tt of Health and Mental Hygiene.<br>If item 27 is marked other than "natuu<br>or other traumatic event, the Medical  | To Be Co         | 17. Father's Name (First, Middle, Last)  L. Bennett   | Sinclair   | Busi                                | ness Exec   |  | e (First, Middle, N<br>W. Ne                      | Printi<br>Maiden Surname<br>ff       |                             |  |
| Maryla                     | 2 should be fill<br>th and Mental<br>27 is marked of<br>traumatic eve   |                  | 19a. Informant's Name/Relationship (Typ   |  | 19b. Mailir                         | g Address (Street a   | and Number or Run                            |   | City or Town, S                      |                             | ,  |
| Baltimore,                 | Page 1 and 2 seent of Health and 1. If item 27 is or other trans  |                  | 20a. Method of Disposition  1  Burial 2  Cremation 3  A  4  Donation 5  Other (Specify)   | emoval from State  | b. Place of Dispo<br>cemetery, cren |   | e)   | Date  | 20c. Location -<br>Timoniu           | City or Tow                 | vn, State  |
| Balti                      | permit. Page 1 a Department of H Important: If ite any injury or ot   |                  | 21. Signature of Funeral Service Licensee   | 11/  | 22<br>R:                            | . Name and Addres   | on Funera                                    | 1 Home,   | 105<br>Inc.Tow                       | 0 Yor                       | k Road   |
|                            | Physician/<br>Medical   |                  | 23a. Part 1. Enter the disease, or corollishock, or heart failure. List/orly one Immediate Cause (Final disease or condition resulting in death)            | cause on each line.  CARDIO  Due to (or as a cons  | death. Do not ente                  | the mode of dying   | g, such as cardiac                           | or respiratory arre                               | st,                                  | 16                          | Approximate<br>Interval Between<br>Onset and Death |
|                            | Examiner  -transit  | cal Examiner     | Osquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last | Due to (or as a cons   | My o C<br>sequence of):             | ARDIA   | L INF  | ARCTIC  | 0N                                   |                             |  |
| 3760                       |   |                  | _ d   |  |                                     |   |  |   |                                      |                             |  |
| . Box 68760                | or Attending Physician: The law requires that the death certificate taffer death. Infer death. Inector: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the I | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | c. If yes, outcome of pre 1  Live Birth 2  4  Pregnant at time 9  Unknown  | Fetal death 3 L                     | Ectopic pregnanc Other (specify)                                | у  |   | 23d. Dat<br>Mor                      | e of deliver<br>nth D       | y<br>Day Year                                      |
| ds, P.O.                   | requires that the bound by should be detained by  |                  | Part II. Other significant conditions con   | ributing to death but not  | t resulting in the u                | nderlying cause giv   | en in Part I.                                | 23e. Did tob                                      | 1                                    |                             | cause of death?                                    |
| Division of Vital Records, | sician: The law red<br>certificate has be<br>lirector, page 2 sho   | Completed by     |   |  |                                     |   |  | 24a. Was an<br>autopsy<br>perform<br>1 \sum Yes 2 | y p<br>ned2/ d                       | rior to com<br>eath?        | sy findings available pletion of cause of          |
| Vital                      | lysician<br>is certifi<br>director  | To Be            | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No  | spital:  | ! ☐ ER/Outpatien                    | Othe  | r:   | k only one)<br>ome 5 🗆 Resider                    | 6 🗆 0***-                            | (C===if.i)                  |  |
| on of                      | ttending Phydeath.<br>death.<br>ctor: After thi<br>y the funeral o  | Certificate: 7   | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation   | 28a. Date of injury<br>(Month, Day, Year   | 28b. Time of                        | 28c. Injury<br>work   | at   | 28d. Describe hov                                 |                                      |                             |  |
| Divisi                     | ital or Atte irs after de al Directo led in by tl   |                  | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  | 28e. Place of Injury - A<br>building, etc. (Spe  |                                     | et, factory, office   | 7  | 28f. Location (Stre<br>City or Town,              |                                      | r or Rural R                | oute Number,                                       |
|                            | To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Af completed filled in by the fu  | Medical          | (Check 2"   Medical Examine only one) 3   Certifying Nurse  | an: To the best of my kn r: On the basis of examina Practioner: To the best of   | ation and/or investi                | gation, in my opinio<br>eath occurred at the                    | n, death occurred at<br>time, date and place | the time, date and<br>e, and due to the o         | d place, and due<br>cause(s) and mai | to the caus                 | e(s) and manner state<br>ed.                       |
|                            | <b>5</b> w t  |                  | 29b. Signature and title of certifier   | a de la companya della companya della companya de la companya della                                      |   | number<br>30263                              | 29  | 9d. Date signed                      |                             |  |
| 1                          |   |                  | 30. Name and address of person who con  | mild in the second second pleted cause of death (I   | tem 23a) (Type, P                   | rint)<br>LER DRI  | UE TO  | DUSON   | MARY                                 | LAND                        | 21204  |

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mogth 2010 21Pay 1:11 PM Henry Alfred Schmitt Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours 1276/1913 Wash. DC 579-07-1112 94 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 United States 5400 Vantage Point Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Bace - American Indian. Armed Forces? 1 ☑ Yes 2 ☐ No 1 Never Married 2 Married Black, White, etc. ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates 1941-45 White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Adjudicator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sophia Maria Cordes John Valentine Schmitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Schmitt Hellauer/Dau. 3712 Valerie Carol Ct. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 4/24/10 Ellicott City, MD Signature of Funeral Service Licensee <sup>22. Name</sup> and Address of Facility Harry H. Witzke's Family F.H. Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 umo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Opset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of a been signed by the attending physician and should be detached for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe has this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred After 1 Natural 5 Pending 2 No Accident Investigation within 24 hours after death To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

only one

31. Date filed (M

29b. Signature and title of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |                  | 4  | epartment of Health and Certificate of Death   | Mental Hygie   | - 2 U i U                                     | 12673   |
|----------------------------|--|------------------|--|--|--|---|---|
|                            | Physicia   |                  | 1. Decedent's Name (First, Middle, Last)  Roy Kennedy Skipton  |  | 2. Date of Death April 20                            | •   | 3. Time of Death<br>8:44 A M                  |
| 4                          | Medi<br>Examir   |                  | 4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital  | 4b. City, Town, or Location of Death   | n  | 4c. County of Death                           | 1   |
|                            | Funeral<br>Director  |                  | 5. Social Security Number   6. Sex   7. Age (in yrs. last birthda   1  | ay) If Under 1 Year If Under 24 Hrs.   |  | g Riet  | nplace (State or Foreign<br>Intry)<br>Inesota |
|                            |  | tor              | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or   | r Location   | rovember 4,  | 1917   11111                                  | 10d. Inside City Limits                       |
|                            | the Maryl<br>or 28a-f<br>e notifie   | Funeral Director | Maryland Montgomery  10e. Street and Number  | Rockville<br>10f. Zip Code   | 10g  | . Citizen of What Co                          | 1 X Yes 2 □ No<br>untry?                      |
|                            | ath with<br>ems 23a<br>must b  | unera            | 303 Adclaire Road. #311  11. Marital Status 12. Was Decedent Ever in U.S.  | 20850  |  | nited Sta                                     |   |
| 9036                       | urs after de<br>ural", or ite  | þ                | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. WWII  | 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☒ No Specify:      | o Rican, etc.)                                       | Black, White                                  | , etc.  |
| Maryland 21215-0036        | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                  | Completed        | (Specify only highest grade completed) (G<br>Elementary/Seconday (0-12) College (1-4 or 5+)  | ecedent's Usual Occupation<br>ive kind of work done during most of wor<br>e. DO NOT use retired)<br>hysician | king   | b. Kind of Business I<br>Medicine             | ndustry                                       |
| and 2                      | be filed v<br>ental Hyg<br>ked othe<br>ic event,   | To Be            | 17. Father's Name (First, Middle, Last)  Roy Edwin Skipton   | 18. Mother's Nar   | me (First, Middle, Maid<br>stabelle A                | den Surname)                                  | 1   |
| Mary                       | 2 should<br>th and M<br>27 is mal<br>traumat   |                  | · · · · · · · · · · · · · · · · · · ·  | lailing Address (Street and Number or Ru   | ral Route Number, Cit                                | y or Town, State, Zip                         | Code)   |
|                            | ige 1 and int of Healt term 2 to other   | NSS              | 20a. Method of Disposition  1 🔀 Buriai 2 🗆 Cremation 3 🗆 Removal from State  20b. Place of Disposition  Are emeterly.  | 951 Middleboro Dri<br>sposition (Name of<br>crematory or other place)<br>On National Augu                    | Date 200   | c. Location - City or                         | Town, State                                   |
| Baltimore,                 | permit. Pa<br>Departme<br>Importan<br>any injury   |                  | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  M01498  | 20. Name and Address of Facility Rot<br>R88 KVIIIe; MBF 134  | ert A. Pu  | <u>lington, V</u><br>mphrey Fur<br>ntgomery / | neral Home/                                   |
|                            |  |                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.                    |  | Approximate<br>Interval Between<br>Onset and Death   |   |   |
|                            | Physician/<br>Medical<br>Examiner  |                  | disease or condition resulting in death)  Acute Myocard:  Due to (or as a consequence of):   |  |  |   | minutes                                       |
|                            |  | iner             | Sequentially list conditions, if any leading to immediate cause. Enter Underlying  |  |  |   | minutes                                       |
| der.                       | ate be executed<br>physician and<br>the burial-transit   | edical Examiner  | Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  |  |  |   |   |
| . Box 68760                | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi | ₹                |  | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)  |  | 23d. Date of deli                             | very<br>Day Year                              |
| s, P.O.                    | ires that th<br>signed by<br>d be detac  | þ                | Part II. Other significant conditions contributing to death but not resulting in the   | ne underlying cause given in Part I.   |  | co use contribute to                          | the cause of death?                           |
| Record                     | The law requate has been page 2 shoul  | Completed        |  |  | 24a. Was an autopsy performed                        | prior to c<br>death?                          | opsy findings available ompletion of cause of |
| Division of Vital Records, | ng Physician:<br>frer this certific<br>ineral director,  | To Be            | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  1 ☐ Inpatient 2 ☒ ER/Outpa  27. Manner of Death 1 ☒ Natural 5 ☐ Pending  1 ☒ Natural 5 ☐ Pending | e of 28c. Injury at  | ck only one)  lome 5  Residence 28d. Describe how in | •   | (y)   |
| Division                   | tal or Attendi<br>rs after death.<br>al Director: A<br>ed in by the fu   | al Certificate:  | 2 Accident Investigation 3 Suicide 6 Could not be determined lower building, etc. (Specify)  | M 1 ☐ Yes 2 ☐ No street, factory, office   | 28f. Location (Street<br>City or Town, St            | t and Number or Rura<br>tate)                 | al Route Number,                              |
|                            | the Hospi<br>hin 24 hou<br>the Funer<br>npleted fill   | Medical          | 29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, dear only one) 3 Certifying Nurse Practioner: To the best of my knowledge.            | vestigation, in my opinion, death occurred at the time, date and pla   | at the time, date and pl                             | lace, and due to the ca                       | ause(s) and manner stated.                    |
|                            | or with  |                  | 29b. Signature and title of certifier  | 29c. License number  Por 68207   | 29d.   | Date signed (Month,                           | Day, Year)                                    |
|                            | 10 x1  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Typ  | 9901 MEDICAL   | CENTER   | DR P.   | KVICCE MO                                     |
|                            | Sta<br>Registr   | te<br>ar         | 31. Date filed (Month, Day, Year)  APR 2 3 2010  Server 3. Registrar's Signature  APR 2 3 2010   |  |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 21 2010 2010 4:19 A M SIEGEL LAWRENCE R Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE PIKESVILLE 14 FARMHOUSE COURT Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Sex 1**X** □ M 2 □ F Days 8/30/1931 78 212-30-4548 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No BALTIMORE PIKESVILLE 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 14 FARMHOUSE COURT 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2 🛣 No WHITE If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) PHARMACIST DONNYBROOK PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SIEGEL JESSE NORMA GOODMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN WERNER/COMPANION 14 FARMHOUSE COURT, PIKESVILLE, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date SHAAREI TFILOH CEM. 4/22/2010 BALTIMORE, MD Ponation 5 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility LEVINSON & BROS 21208 8900 REISTERSTOWN ROAD, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Veau disease or condition resulting in death) ) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death signed by the at d be detached fo 4 ☐ Pregnant 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? has page 2 1 Yes 2 INO certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at : After t 1 Watural 5 Pending worl 2 Accident
3 Suicide 2 🗌 No s after death. I Director: Af 1 🗌 Yes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

within 24 hours a To the Funeral I

State Registrar

29a. Certifier

(Check

31. Date filed (Month, Day, Year)

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Idress of person who completed cause of death (Item 23a) (Type, Print)

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MALINON

Cyrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town or Location of Death Examiner MORO 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F unk yrs Min (Month, Day, Year) unk Country) **Director** unk 220-40-4616 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director or 28a-f s notified 1 Xyes 2 No Marvland Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ò Examiner must be Funeral with 23a 2700 N. Charles Street 21218 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Eant, If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🙀 No 11 Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Black er than "natur , the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Construction Worker</u> Labor is marked other aumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Albert Thompson Mary Core 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Salmond/friend 2605 List Avenue Baltimore, Maryland 21214 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Departion 5 ☐ Other (Specify) Journey Crematory 4/23/2010 Woodbine, Maryland Name and Address of Facility arisse N. Woods Funeral Service 00 Edmondson Avenue, Baltimore, re of Funeral Service stina Maryland 21223 M00957 23a. Part Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 performed 1 Yes 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death Check only one) Be examiner? Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? Natural 5 Pending 2 No Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

only or 29b. Signat

e and title of certifie

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31. Date filed (Month, Day, Year)

and address of person wha completed cause of death (Item 23a) (Type, Print)

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Registrar's Signatu

within 2 To the

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death TAYLOR Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, 4c. County of Death **Examiner** Arundel Medical Center trunde mapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Morth, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 🗆 M 2 🗷 F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. Stațe 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gler 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral lolol Highway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Vivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Health Care Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Veav Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ onnie Taylor Doreatha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14401 Dunstable Court Bowie MD 20721 Mi Davius la 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Woodlawn, HD Woccilawn Coneten 4 Donation 5 Other (Specify) Vaughor C. Greene Funeral SVCS . Signature of Funeral Service Licenses Vai Road Randa Ustown MD 21133 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and ready Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sagno tially life conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnation 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 1 ☐ Yes 2 € 9 ☐ Unknown Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: ✓Inpatient 2 □ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the pasis of examination allows investigation, in the pasis of examination allows investigation, in the pasis of examination allows in the examination allows in the pasis of examination allows in the e only one) 29b. Signature and title of certifie Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 76/4 u

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 16b per FH g902 4/23/10 TT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARY E. THOMPSON 3:20 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKING BAYVIEW MEDICAL CENTER BALTIMORE CITY BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Days Hours Min Months 83 Director 213-26-5178 Usual Residence of Deceden show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director · 28a-f MD 1 XYes 2 No na Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2205 Bluegrass Heights Ct 21237 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" Specify: Completed 3 Widowed 4 Divorced Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Regional Management Housekeeping 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 1 and 2 should b of Health and Mer fitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2205 Bluegrass Heights Ct Maria Laws-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town. State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Greenmount 4-29-2010 21. Signature of Funeral Service Licenses March East F/H 22. Name and Address of Facility 21202 1101 Ε. North Avenue Balto, MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS Medical resulting in death) Due to (or as a consequence of) Examiner PNEUMON) A week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) CELL CAREINOMA OF THELUNG 1 year attending physician and for use as the burial-transit SOUMMOUS law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 3  $\square$  Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown the 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c COPD, CHRONIC PULMONARY EMBOY, REMOTE Records, 1 Tes 2 No 3 Probably 4 Unknown HISTORY OF BLADDER CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed Hospital or Attending Physician: The certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Nanatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License numbe 29d. Date signed (Month, Day, Year) M.D. Sevan Ana 16,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARAH SHARFSTUN, M. D. 4940 EASTERN AVENUE BALTMORE, MD 31. Date filed (Month, Day, Year) APR 2 3 37. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per me, g902,04627/62019diftDeath Reg. No. tia Name (First, Middle, Last) 2. Date of Death ADRI Physician /Medical a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2X F 220-32-3558 73 March 31, 1937 **Director** Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at MD Baltimore Baltimore Funeral Director 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21234 US.A. 1905 Rushley Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ò 1 Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **At Home** other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Evans Mary Catherine Meighan marked ည traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) S nt of Health a : If item 27 is or other trau Cheryl Donald/Daughter 1905 Rushley Road, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel- Bel Air 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. 4 Donation 5 Other (Specify) Forest Hill, Maryland Chapel 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chapel & Cremetion Services 8800 Harford Road, Parkville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Immediate Cau e Final Onset and Death **Physician** ntraventrica disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HOVED BY MEDICAL EXAMINER Due to (or as a consequence of) Due to (or as a consequence of) CERTIFIC Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? page 2 should be detached for Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 KUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Physician: 26. Place of Death (Check only one) Be Hospital: Other: 4 🗌 Nursing Home 5 🗆 Residence 1XInpatient 2 ER/Outpatient 3 DOA ၉ the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1X Natural 5 Pending investigation Injury s after death. Accident 1 TYes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only Within 2 the

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State Registrar 31. Date filed (Month, Day, Year) **APR 2 3 2010** 

30. Name and address of person who

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ros

2. Registrar's Signature

empleted cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

18,2010

00069625

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year MADGE WICK 13:22 PM 2010 04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 1, 1925 g. Birthplace (State or Foreign **Funeral** 1 □ M 2 ▼ F 402-32-7492 84 Kentucky **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director Montgomery Rockville 1 Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15309 Hannans Way 20853 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify:White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever ၉ Robert Franklin Bellamy Elizabeth Jane Shuler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 15309 Hannans Way, Rockville, MD. 20853 Everett A. Wick (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Chesapeake Crematory Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRapp Funeral & Cremation Service Signature of Funeral Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATHERUSCLEROTIC CARDIOVASULAR DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in the line to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of ending physician and use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ►ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on The certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 aug 04,21,10

State Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

18101 Prince Philip Dr. Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $DARCIE HAMMD (18101\ Princ)$ 

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** liams 201 /Medical 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner evinda more Date of Birth (Month, Day, Year)
5-31-1924 . Social Security Numbe 7. Age (In yrs. last birthday) (State or For **Funeral** Months Davs Hours 1 □ M 2 □ F MD 85 Director 577-32-7695 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No MD Funeral Director na Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 4402 Chalet Cour 21206 S A 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M J.H. H. Radiology Tech 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Coleman Martha Deale 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2205 Hamiltowne Circle Balto, MD 21237

Date | 20c. Location - City or Town, State Mary Banks-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 4-24-2010 Hyattsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Gronan disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if a pleading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 22 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 10 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural
2 Accident 5 Pending investigation I Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral DI

completely filled ir 1 Portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and til DO056414 U-17-2010. who completed cause of death (Item 23a) (Type, Print) 2434 West Belvedere Avenue, Baltimore, MD 21215 31. Date filed (Month, Dayl Year)

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month C4 Day 16 SYITI Washington 0643 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical NIA Baltimere, MD 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 M 2 Hours Min. (Month, Day Country Director Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White\_etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes. Give 3 Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lar tha 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 2-2010 mem, Pl 4 Denation 5 Other (Specify) ture of Funeral Service Lice Lee 22. Name and Address of Facility 405 nd. 21225 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the model dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Due to (or as a consequence of): 5 years Service Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 2 9 Unknown To the Funeral Director: After this certificate has been signed by the or completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Natient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? 1 Natural 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

within 24 hours after deat To the Funeral Director:

State Registrar

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifier

Baltimore

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

22 Sough bicene St.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Genifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1861627739

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month C. White Eleanore April 2010 6:58A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 182 Obrecht Road Millersville Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🕮 F Days Hours Sept. 8,1928 216-24-4591 81 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 182 Obrecht Road 21108 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 X Married ≥ Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify White Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important. If item 27 is marked of any injury or other traumatic eve and Mental 2 Joseph F. Bury Rose Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Tony Emerson /Daughter Millersville, MD 21108 182 Obrecht Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) rigion ) Medical Due to (or as a consequence of): Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 nonths?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 V 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ၉ 1 🗌 Yes 4 Nursing Home this ( 1 Inpatient 2 ER/Outpatient 3 DOA X Residence 6 C Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 2 🗆 No 1 Tyes Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 110 Name and address of person who co ted cause of death (Item 23a) (Type, Print) 80g

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |  |                               | State of Maryland / De  |  |   | rgiene                            | 10000                                 |
|---|--|-------------------------------|---|--|---|-----------------------------------|---------------------------------------|
|   |  |                               | Registrar  1. Decedent's Name (First, Middle, Last)   | ertificate of Death  |   | Reg. No.                          | 1 2683                                |
|   | Physicia   |                               | Paul Sibley Williams  |  | 2. Date of De<br>Month<br><b>April</b>                | 19, Day 2010 Year                 | 3. Time of Death 6:50 P M             |
|   | Medic<br>Examin  |                               | 4a. Facility Name (if not institution, give street and number)  | 4b. City, Town, or Location  |   | 4c. County of Dea                 |                                       |
| -   |  |                               | Manor Care-Potomac  | Potoma   | .c  | Montgome                          | ry                                    |
|   | Funeral  |                               | 5. Social Security Number 6. Sex 7. Age ( <i>ln yrs. last birthda</i> 1.  | Monthe Dave Hours  | er 24 Hrs. 8, Date of Bi                              | th 9. Bit                         | thplace (State or Foreign             |
|   | Director   |                               | 555-16-7633   1 M M 2 L F   85 Yrs  |  | July 26   | 7, 1924  Cal                      | ifornia                               |
|   | and<br>show  | or                            | 10a. State 10b. County 10c. City, Town or   | Location   |   |                                   | 10d. Inside City Limits               |
|   | Maryl<br>28a-f<br>ptifiec  | rect                          | District<br> of Columbia  | Washington   |   |                                   | 1 ☐ Yes 2 🛣 No                        |
|   | h the sa or s  | al Di                         | 10e. Street and Number  | 10f. Zip Code  |   | 10g. Citizen of What Co           | ountry?                               |
|   | th wit<br>ms 23<br>must  | ıner                          | 2918 Upton Street, NW   | 20008  |   | United Sta                        |                                       |
| -   | or iter  | Completed by Funeral Director | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 ☑ Married  12. Was Decedent Ever in U.S. | <ol> <li>Was Decedent of Hispanic O<br/>If Yes, specify Cuban, Mexica</li> </ol> | rigin? (Specify Yes or No-<br>an, Puerto Rican, etc.) | 14. Race - Ame<br>Black, Whit     |                                       |
| 98  | s afterral",   | q pe                          | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. WWII   | 1 ☐ Yes 2X No Specif   | y:  | Specify: Wh                       | ite                                   |
| 5-0                                       | hour "natu   | plet                          | 15. Decedent's Education 16a. De  | cedent's Usual Occupation<br>we kind of work done during mo                      | net of working  | 16b. Kind of Business             | Industry                              |
| 12  | hin 7%<br>ne.<br>than  | mo                            | Flementary/Seconday (0-12) College (1-4 or 5+)  | DO NOT use retired) ormation Offic   | -   | Federal G                         | overnment                             |
| 9   | ed wil<br>Hygie<br>other<br>ent, th  | 00                            | 17. Father's Name (First, Middle, Last)   |  | her's Name (First, Middle,                            |                                   |                                       |
| an  | be fill<br>ental<br>rked c   | 욘                             | Paul Williams   |  | hyllis Pick   |                                   |                                       |
| Maryland 21215-0036                       | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  |                               | 19a. Informant's Name/Relationship (Type, Print) 19b. Ma  | illing Address (Street and Numb  | ber or Rural Route Numbe                              | er, City or Town, State, Zi       | p Code)                               |
|   | nd 2 sealth an 27 i  |                               |   | 8 Upton Street   | , NW Washin   | gton, D.C.                        | 20008                                 |
| Baltimore,                                | t of Hart of Hitel   | 0                             | . D D   | position (Name of rematory or other place)                                       | April 22,   | 20c. Location - City or           | Town, State                           |
| ţi  | it. Pag<br>rtmen<br>rtant:<br>njury  |                               | 4 Donation 5 Other (Specify)  | ery<br>ium, Inc.   | 2010  | Bethesda                          | , Maryland                            |
| Ba  | permi<br>Depar<br>Impor<br>any ir  |                               | 21. Signature of Funeral Service Licensee  M01498   | 22. Name and Address of Faci<br>Bethesda-Chevy<br>Bethesda, Mary                 | Chaseas Inc   | . 7557 Wisc                       | onsin Avenue                          |
|   |  |                               | 23a. Part 1. Effer the disease, or complications that caused the death. Do not e  |  |   |                                   | Approximate                           |
|   | Physician/   |                               | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Severe Cardiom        | war a that   |   |                                   | Interval Between<br>Onset and Death   |
|   | Medical  |                               | disease or condition resulting in death)  a. Severe Cardiom Due to (or as a consequence of):                                  |  | years   |                                   |                                       |
|   | Examiner   | <u>.</u>                      | Sequentially list conditions, b. Arrythmia  |  |   |                                   | years                                 |
| $\overline{}$                             | sit sit  | mine                          | if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Hypartansi on                                  |  |   |                                   |                                       |
| M   | xecute<br>n and<br>al-tran   | Exal                          | Cause (Disease or linjury that initiated events resulting in death) Last  C. Hypertension  Due to (or as a consequence of):   |  |   |                                   | years                                 |
| 0   | e be executed<br>ysician and<br>e burial-transit   | dical Examiner                | d   |  |   |                                   |                                       |
| 876                                       | ificate<br>ng phys<br>as the   |                               | IF FEMALE:  |  |   | 7                                 |                                       |
| 9 ×                                       | ath certifica<br>attending p<br>for use as   | an/l                          | 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy  | ☐ Ectopic pregnancy  |   | 23d. Date of de                   | -                                     |
| Bo  | t the deat<br>by the at<br>tached fo   | Physician/Me                  | 1   Yes 2   No 4   Pregnant at time of death 5 9   Unknown  | Other (specify)  |   | Month                             | Day Year                              |
| 0.  | that the   |                               | Part II. Other significant conditions contributing to death but not resulting in th   | underlying cause given in Par  | t I. 23e. Did t                                       | obacco use contribute to          | the cause of death?                   |
| S, F                                      | ires the sign of t | Completed by                  | Osteoporosis  |  | 1 🗆   | Yes 2. No 3 □ P                   | robably 4 🗆 Unknown                   |
| ord                                       | v require<br>s been si<br>should I   | olete                         | Congestive Heart Failure  |  | 24a. Was  | an 24b. Were au                   | topsy findings available              |
| <b>3ec</b>                                | The law<br>cate has page 2 s   | mo;                           | Dementia  |  | auto<br>perfo<br>1 🗆 Yes                              | ormed? death?                     | completion of cause of                |
| E   | sician: The<br>certificate<br>rector, pag  | Be                            | 25. Was case referred to medical examiner?  |  | ath (Check only one)                                  | 2 10 10                           |                                       |
| Ž   | Physic<br>this or  | 유                             | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  |  | Nursing Home 5 Resid                                  |                                   | cify)                                 |
| 0 U                                       | ding I<br>h.<br>After<br>funer   | sate                          | 1 Natural 5 ☐ Pending (Month, Day, Year) injury   |  |   | now injury occurred               |                                       |
| Sio                                       | il or Attendi<br>s after death<br>I Director: A<br>d in by the fu  | Certificate:                  | 2   |  |   | Street and Number or Ru           | ral Route Number.                     |
| Ο̈́                                       | pital or At<br>ours after ours after of<br>eral Directilled in by  |                               | building, etc. (Specify)  |  | City or Tov   |                                   | · · · · · · · · · · · · · · · · · · · |
| Division of Vital Records, P.O. Box 68760 | To the Hospital within 24 hours a To the Funeral L completed filled  | Medical                       | 29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or inv                                       | n occured at the time, date and  | d place, and due to the ca                            | use(s) and manner as sta          | ated.                                 |
|   | the H<br>thin 24<br>the F<br>mplete  | Me                            | only one) 3 L Certifying Nurse Practioner: To the best of my knowledge  | e, death occurred at the time, dat   | te and place, and due to th                           | e cause(s) and manner as          | stated.                               |
|   | ნ. <u>ა</u> ზიე  |                               | 29b. Signature and title of certifier   | 29c. License number  | 9   | 29d. Date signed (Month) 4 20 - 2 |                                       |
|   |  |                               | 30. Name and address of person who completed cause of death (Item 23a) (Type  | Print)   | <u> </u>  | 10000                             | 10:                                   |
|   | 20+1   |                               | Reman Tuli M D 10810 Darretown B  | oad #202 Gait  | hersburg, M   | aryland 208                       | 78                                    |
|   | Stat   | е                             | 31. Date filed (Month, Day, Year) APR 2 3 2010 32. Registrar's Signature  | red .  |   |                                   |                                       |
|   | Registra   |                               |   | T T T T T T T T T T T T T T T T T T T  |   |                                   |                                       |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year 19 4:25 P Mae Woodley Ziglar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15115 Interlachen Dr. #222 Silver Spring Montgomery 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Hours MAR 18, 1915 North Carolina Director 95 578-42-2256 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f s 1 ☐ Yes Ž 🖰 No Silver Spring Maryland Montgomery 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ក 23a Funeral United States 20906 5115 Interlachen Dr. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married ō. ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours aft and Mental Hygiene. If Yes, Give Specify: White 3 → Widowed 4 □ Divorced Completed Year or Dates. pernit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Assistant U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Indiana Davenport William Bailey Woodley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Ziglar / Son 25007 Woodfield Rd., Damascus, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 4/23/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se 22 Rappd funeration Services M00382 Silver Spring, MD 933 Gist Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) HEART FAILURE Concested Meny TH Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. First I mornying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the builal-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes ∠ J 9 ☐ Unknowr Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🕱 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

State

JAMES.

31. Date filed (Month, Day, Year)

Registrar

3305 N. LEISUNEWERLD

BLUD

maly mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alexande 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death pluta 20646 La 7. Agg/In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | B. Birthplace (State or Foreign Country) 6. SeM 2□ F 5. Social Security Number Months Days Hours 111-36- 752 Usual Residence of Decedent Massachusetts 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√2 Yes 2 No La Plata Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20646 301 Alder Court 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Printing Printer 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Minnie Parks Arthur Percival Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Alder Court La Plata, Maryland 20646 Lois J. Bakondi/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ Removal from State Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 4-8-2010 Brinsfield-Echols 21. Signature of Funeral Service Fee 22. Name and Address of Facility Arehart-Echols Funeral Home 211 St. Mary's Ave. La Plata, Maryland 20646 M01458 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No

**Physician** /Medical Examiner The law requires that the death certificate be executed

1-

10a. State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

e 23a or 28a-f ehow

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27 is marked other than "natural traumatic event, the Mudical Land

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Pages 1 and 2 should be

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Funeral

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filed within 72 hours after death

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

atten for u signed by the been si certificate this After thi

Physician/Medical Completed by Be

4 Homicide

29a. Certifier

29b. Signature

Examine Certification: To

Medical

death. Director: / illed in by within 24 hours after To the Funeral Dire

To the Hospitai BOW

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. wrian 25. Was case referred to medical examiner? 26. Pluce of Death | Check only one 1 Yes 2 No Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide

2Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

acoma P( Wald

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29c. License number D0062304

29d. Date signed (Month, Day, Year)

Hom

31. Date filed (Month, Day, Year) APR 0 9 2010

e of certifie

32. Registrar's Signature

State

Registrar

| Hector | Ismael | Avala |
|--------|--------|-------|
|        |        |       |

| ector Ismael A  | yala           | 1- For State  | e of Maryla   |                      | artment of<br><i>rtificate of</i>            |                    | n and                    | Menta               | al Hyg     |                               | og No        | 20                  | 10             | 1268   |
|---|----------------|---|---|----------------------|--|--------------------|--------------------------|---------------------|------------|-------------------------------|--------------|---------------------|----------------|--|
| Physicia<br>ledical Exami   |                | 1. Decedent's Name (First, Middle,La  | •   |                      | -  |                    |                          |                     |            | Date of Dea<br>Month          | Day          | Year                | 3              | 3. Time of Death                               |
| leuicai Exami   | ilei           | 4a. Facility Name (if not institution, g  | ive street and nur  |                      |  | b. City, To        | wn, or Lo                | ocation of I        |            | April 4, 20                   | 4c.          | County of I         |                |  |
| . 1   | Ц              | Holy Cross Hospital   |   |                      |  | Silver             |                          |                     |            |                               |              | ontgome             |                | 701  |
| Funeral<br>Director   |                |   |   | 7. Age (In yrs. I    | -  | If Under<br>Months | 1 Year<br>Days           | If Under 2<br>Hours | Min.       |                               |              | F                   | Foreign        | place (State or                                |
| 3   |                | 151-94-7628 1 Usual Residence of Decedent   | <b>X</b> M 2 F  | 3                    | Yrs.   |                    |                          |                     | 1          | 01/1                          | 4/19         | 79                  | Coun           | try) <b>N</b> J                                |
| any   |                | 10a. State 10b. County  |   | 10c. City            | , Town or Locati                             | on                 |                          |                     |            |                               |              |                     | - 1            | 0d. Inside City Limits                         |
| Aaryland<br>28a-f show<br>1 at once.  | ٥.             |   | imore   |                      |  |                    |                          | dalls               | town       |                               |              |                     |                | 1 Yes 2 X No                                   |
| e Mary<br>or 28a-   | Director       | 10e. Street and Number  |   |                      |  | 10f. Zip C         |                          |                     |            | 1                             | 0g. Citizo   | en of What          |                | •  |
| oith the s 23a o  |                | 8413 Horat  11. Marital Status  |   | edent Ever in U      | S 13 Wa                                      | s Decedent         |                          | 1133                | 2 (Spec    | ify Yes or No                 | ) I 1        |                     | U.S<br>America | n Indian, Black,                               |
| leath w   | uneral         |   | rital Status  Never Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No |                      |  |                    |                          | Mexican, P          |            |                               |              | White, e            |                | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,        |
| rall", o  | by F           |   | ed If Yes, Give Year or Dates:  |                      |  |                    |                          |                     |            | cto Ri                        |              |                     |                | White  |
| hours "natu   |                | 15. Decedent's Education (Specify Elementary/Secondary (0-12)                                   | only highest grade<br>College (1-   |                      | during most of working life, DO NOT use reti |                    |                          |                     |            |                               | 16b. Ki      | ind of Busin        | ness/Ind       | lustry   |
| 5-0036 led within 72 Hygiene. other than '  | Completed      |   | 4   |                      | 1  | Police             | e 06                     | ficer               | L          |                               | La           | w Enf               | orc            | ement  |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fsh matic event, the Medical Examiner must be notified at once |                | 17. Father's Name (First, Middle, Las   | •   |                      | 1  |                    | 18                       | B. Mother's I       | ,          | irst, Middle,                 |              | ,                   |                |  |
| 2121;<br>uld be fil<br>Mental F<br>marked   | To Be          | Hect 19a. Informant's Name/Relationship (   | Cor Ayala<br>(Type. Print)  |                      | 19b. Mailing                                 | Address            | (Street a                | and Numbe           |            | z <i>Hayd</i><br>al Route Nur |              |                     | State, Z       | ip Code)                                       |
| and 2 shou lealth and N tem 27 is n traumatic   |                | Melissa Ayala   |   |                      | ill.   |                    |                          |                     |            |                               |              |                     |                | nd 21133                                       |
| ore, M<br>es 1 and 2<br>of Health<br>If item 2  |                | 20a. Method of Disposition  1 X Burial 2 Cremation 3  |   |                      | Place of Disposi                             | tion (Name         | of ceme                  |                     |            | ate                           |              | ocation - Ci        |                |  |
| Page<br>ent cent  |                | 4 Donation 5 Other Specif   |   | M                    | laney v<br>Laney V<br>emorial                | Gard               | 2ns                      |                     | 4/09       | /2010                         | Tim          | onium               | 1, M           | aryland  |
| Baltime<br>Permit. Pag<br>Department<br>Important:<br>injury or of  |                | 21. Signature of Funeral Service Lice   | ensee   | .00                  |  |                    |                          |                     |            |                               |              |                     |                | Home, Inc.                                     |
| Physician   | -              | 23a. Part I. Enter the disease or com   | nplications that ca   | used the death       | . Do not enter th                            | e mode of          | <b>W HO</b><br>dying, su | uch as card         | tiac or re | AUE.,<br>spiratory arr        | est, shoc    | k, or heart         | price          | 19. MD20904<br>Approximate Interval            |
| /M di al<br>Examiner  | 1              | mmediate Cause (Final disease a. Multiple Injuries Death  |   |                      |  |                    |                          |                     |            |                               |              |                     |                | Between Onset and<br>Death                     |
| LAAIIIIICI  |                | or condition resulting in death)  | Due to (or as a   | consequence o        | f):  |                    |                          |                     |            |                               |              |                     |                |  |
|   | 힐              | Sequentially list conditions, if any, leading to immediate                                      | Due to (or as a   | consequence o        | f):  |                    |                          |                     |            |                               |              |                     | 1              |  |
|   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a   | consequence o        | f):  |                    |                          |                     |            |                               |              |                     | -              |  |
| Box 68760, he death certificate be executed y the attending physician and hed for use as the burial - transit   |                |   |   |                      |  |                    |                          |                     |            | $\dashv$                      |              |                     |                |  |
| O,<br>be exersician   | edical         | UNPENDED  | AMENDED   |                      |  |                    |                          |                     |            |                               |              |                     |                |  |
| 876<br>tificate<br>ng phy<br>as the   | sician/M       | IF FEMALE;<br>23b. Was decedent pregnant in the<br>past 12 months?                              | 23c. If yes, or 1 Live bir  | utcome of preg<br>th |  | al death           | 3                        | Ectopic pr          | regnancy   | /                             |              | Date of de<br>Month | elivery<br>Day | y Year   |
| Records, P.O. Box 6876( The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the b  | sicia          | 1 Yes 2 No 9 Unknow   | 7   | nt at time of de     | eath 5 Oth                                   | er (Specify        | <i>(</i> )               |                     |            |                               |              |                     |                |  |
| D. B. Ithe de by the ached f  | Phy            | Part II. Other significant conditions   |   |                      | esulting in the u                            | nderlying ca       | ause giv                 | en in Part I        | l.         | 23e. Did to                   | bacco us     | se contribu         | te to the      | e cause of death?                              |
| ires that the do  | d b            |   |   |                      |  |                    |                          |                     |            | 1 Yes                         | 2 🗸          | No 3                | Probab         | oly 4 Unknown                                  |
| ords<br>w requir  | lete           |   |   |                      |  |                    |                          |                     |            | 24a. Was<br>autop             |              |                     |                | osy findings available<br>apletion of cause of |
| Recol<br>The law<br>cate has  | Completed      |   |   |                      |  |                    |                          |                     |            | perfo<br>1 Yes                | rmed?<br>2No |                     | ath?<br>✓ Yes  | 2 No   |
| tal Rection: The certificate ector, page  | Be C           | 25. Was case referred to medical examiner?  | Hospital:   | (111)                |  |                    | -                        | f Death (Ch         |            |                               |              |                     |                |  |
| of Vi<br>Physical this eral dir   | ျ              | 1 Yes 2 No 27. Manner of Death  | 28a. Date o   | -                    | ER/Outpatient<br>28b. Time of Ir             |                    |                          | ther 4 N            |            | d. Describe                   | Residen      |                     | Other:         |  |
| ion of tending Pheath.  | Ęį             | 1 Natural 5 Pending   | Apr 4, 20   | Qay, Year)<br>10     | 0124 hrs                                     |                    |                          | s 2 N               | اصدا       | iver auto                     |              |                     |                |  |
| Division of Vital Records, tal or Attending Physician: The law require rs after death.  al Director: After this certificate has been sited in by the fluneral director, page 2 should be                                  | Certification: | 2 Accident Investiga 3 Suicide 6 Could no   | 28e Place   | of Injury - At he    | ome, farm, stree                             | t, factory, o      | ffice buil               | lding, etc.         | 28         | f. Location (                 |              | d Number o          | or Rural       | Route Number, City                             |
| Di<br>ospital o<br>hours a<br>uneral I  |                | 4 Homicide determine  | (0,000))  |                      | d / Highway                                  |                    |                          |                     | - 1        | 00 block of                   | Randol       |                     |                | Spring, MD                                     |
| Division of Vital F<br>To the Hospital or Attending Physician:<br>within 24 hours after death.<br>To the Funeral Director: After this certifi<br>completely filled in by the funeral director,                            | Medical        | (Check only one) 2 Medical Examine  | er: On the basis of   | examination a        |  |                    |                          |                     |            |                               |              |                     |                | ause(s)  |
|   | Me             | 29b. Signature and title of certifier   | and manner sta  | ited                 |  | 29c. L             | icense r                 | number              |            |                               | 29d. Da      | ate signed          | (Month         | , Day, Year)                                   |
| 25  |                | D_10 L_1  |   |                      |  | (                  | D.C.M.                   | .E.                 |            |                               | April        | 4, 2010             |                |  |
|   | ļ              | 30. Name and address of person who Donna M. Vincenti, MD  | completed cause   |                      |  | Penn St            | reet C                   | Raltimore           | MD.        | 21201                         | •            |                     |                |  |
| Sta   | ate            |   |   | istrar's Signatu     |  |                    | icci, E                  |                     | J, IVID /  | _1201                         |              |                     |                |  |
| Regist  | rar            | 31. Date filed (Month, Day Year) 2010   | Deneu   | 400                  | park   |                    |                          |                     |            |                               |              |                     |                |  |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 2 Ortificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BERNICE L. ASHLEY APRIL 7:45 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent Chester River Hospital Chestertown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. sept 14 Year) 929 Maryland **Director** 80 <u>217-28-3745</u> Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Oueen Anne's Sudlersville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be Funeral 601 Foxxtown Dr. Apt. 314 21668 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 Yes 2 XNo Specify: "natural", 3 X Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Garment Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Lineworker Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Ringgold Clara Briscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Benson, Sr. (son) 31822 River Rd. Millington, MD. 21651 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State matory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Graves Chapel Cemetery 4/24/10 Millington, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech
Galena MD. 21635 21. Signature Fineral Service M00510 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Cardiac Arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir Non-Insulin dependent diabetes mellitus ng physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ģ in the past 12 months?
1 ☐ Yes 2 🛣 No Year Month Day been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes, Hx. Ovarian Cancer 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? 1 Yes 2 No this certificate Yes 2X No After this certification, I Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No 1 🔀 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

251 S. Bohemia Ave.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul M. Katz, DO

PR 23 201

31. Date filed (Month, Day, Year)

H0056426

Cecilton, MD. 21913

4/19/2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                |   |               | 1 - For<br>State<br>Registrar  |  | partment of Health and M<br>e <i>rtificate of Death</i>  | Reg. N   |  |
|----------------|---|---------------|--|--|--|--|--|
|                | Division  |               | 1. Decedent's Name (First, Middle, La  | st)  |  | 2. Date of Death<br>Month D                    | 3. Time of Death   |
|                | Physici<br>/Medio   |               | Geneva Delore  |  |  | April 7,                                       | 2010 05: 29A. M  |
| )              | Examir  | er            | 4a. Facility Name (If not institution, give  |  | 4b. City, Town, or Location of Death   |  | c. County of Death   |
|                |   | Ш             | Prince George 5. Social Security Number 6. S   | s Hospital Center  | Cheverly  If Under 1 Year   If Under 24 Hrs.   | 8. Date of Birth                               | Prince George's  |
|                | Funeral<br>Director   |               | 579-88-8810  | Sex 7. Age (In yrs. last birthda<br>1 M 2 46 Yrs.  | Months Days Hours Min.   | 04/24/1963                                     | 9. Birthplace (State or Foreign Country) Wash., D.C.                       |
|                | land land   |               | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or   | Location   |  | 10d. Inside City Limits  |
|                | Mary  | ţo            | D.C.   | Washi  | ngton  |  | 1. Yes 2 □ No  |
|                | r 28a   | Director      | 10e. Street and Number   |  | 10f. Zip Code  | 10g. C   | Citizen of What Country?   |
|                | th wit  | al D          | 5904 Eads St.,   | N.E.   | 20019  |  | U.S.A.   |
| 1215-0036      | filed within 72 hours after death with the Maryland<br>Hygiene.<br>kher then "naturel", or ttems 23a or 28s-f show<br>int, Ita Medical Examinar must be notified at | by Funeral    | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Ever in U.S. Armed Forces? 1  | . Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto<br>1 ☐ Yes 2 ☑ No Specify:   | ecify Yes or No-<br>Rican, etc.)               | 14. Race - American Indian, Black, White, etc.  Specify: African— American |
| Ö<br>O         | 72 ho   | ted           | 15. Decedent's E   |  | edent's Usual Occupation<br>re kind of work done during most of worki  | 16b.   | Kind of Business/Industry  |
| 7              | e e   | Completed     | Elementary/Secondary (0-12)  | College (1-4or 5+)   | DO NOT use retired)  | ,,,g   |  |
| 2              | filed w<br>Hygier<br>Ather th   | Co            | 11th   |  | Secretary / Pentagor   |  | .S. Government   |
| Maryland 21    | a a b   | Be            | 17. Father's Name (First, Middle, Last<br>Alexander Brown  |  |  | (First, Middle, Maide                          |  |
| Ξ              | should by   | 2             | 19a. Informant's Name/Relationship   |  | ling Address (Street and Number or Rura  | es Andrews                                     |  |
|                | d 2 s<br>h ar<br>7 is<br>trau   |               |  | illiams/Daughter 590   |  |  |  |
| ē,             | - I = =   |               | 20a. Method of Disposition   | 20b. Place of Dis  | A SECURIT OF THE PROPERTY OF T |  | Location - City or Town, State   |
| Ë              |   |               | 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Con | Themoval from State Charanas   | ke Crematory, Inc. (   | 04/12/10 B                                     | eltsville,Maryland   |
| Baltimore,     | permit. Pag<br>Department<br>Importent: f<br>any injury o   |               | 21. Signature of Funeral Service Lice  | 1 () all   | 22. Name and Address of Facility Henry S. Washing  | ton & Sons                                     | Co., Inc.  |
|                |   |               | 23a. Part1. Enter the disease, or com  | plications that caused the death. Do not e one cause on each line.   | 925 Burroughs Ave., nter the mode of dying, such as cardiac of   | r respiratory arrest,                          | Approximate Interval Between   |
| 4              | Physician   |               | Immediate Cause (Final disease or condition resulting in death)  | . Fatal Card   | iac Arrythmia  |  | Onset and Death  |
|                | /Medical<br>Examiner  |               | <b>1</b>   | Due to (or as a consequence or);   | •  |  |  |
|                |   | er            | Sequentially list conditions, if any, leading to immediate   | b. Hyperkaler Due to (or as a consequence of):   | ma   |  |  |
|                | d<br>d<br>ansit   | Examin        | cause. Enter Underlying Cause (Disease or injury that initiated events   | Seosis   |  |  |  |
| Ď              | exec<br>en an<br>rial-tr  | Exa           | resulting in death) Last   | Due to (or as a consequence of):   |  |  |  |
| 28 / 6U        | ficate be executed<br>physicien and<br>is the burial-transit  | edical        | •  | · Recurrent  | Preumonia  |  |  |
| õ<br>×         | ing pl  | Med           | IF FEMALE:   | 00-16-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-   |  |  |  |
| <b>O</b>       | the death certif<br>y the attending<br>iched for use as   | Physician/M   | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  |  | ☐ Ectopic pregnancy ☐ Other (specify)  |  | 23d. Date of delivery  Month Day Year                                      |
| ds, P.         | law requires that the de<br>as been signed by the a<br>2 should be detached   | ρ             | Part II. Other significant conditions  | contributing to death but not resulting in the   | underlying cause given in Part I.  |  | o use contribute to the cause of death?<br>2⊠No 3 □ Probably 4 □Unknown    |
| Ö              | v requ<br>been<br>shouk   | letec         |  |  |  |  |  |
| Vital Records, | The lar   | Completed     |  |  |  | 24a. Was an autopsy performed?                 |  |
| <u> </u>       | Physician: Th<br>this certificete<br>ral director, pag  | Be            | 25. Was case referred to medical examiner?   | Hospital:  | Othor  | (Check only one)                               |  |
| ō              | Phys<br>this<br>raldii  | 70            | 1 ☐ Yes 2 No  27. Manner of Death  | 1 ☐ Inpatient 2 ER/Outpate 28a. Date of Injury 28b. Time   |  | me 5 Aesidence<br>28d. Describe how in         | 6 □Other (Specify)   |
| 0              | ding<br>th.<br>After<br>funer   | tlon          | 1 Natural 5 Pending 2 Accident investigatio  | (Month, Day Year) Injury   |  | Edd. Describe now in                           | ury occurred   |
| DIVISION       | Attending r death. ector: After by the fune   | ertification: | 3 ☐ Suicide 6 ☐ Could not b  | e 28e. Place of Injury - At home, farm,  |  |  | and Number or Rural Route Number,  |
| 5              | s afte  | Cert          | 4 Homicide   | building, etc. (Specify)   |  | City or Town, Sta                              | ife)   |
|                | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f  | edical        | 29a. Certifier Check only one) Certifying Pl   | nysician: To the best of my knowledge, de<br>miner: On the basis of examination and/or<br>and manner stated. | ath occurred at the time, date and place, a<br>investigation, in my opinion, death occurr  | and due to the cause<br>ed at the time, date a | (s) and manner as stated. nd place, and due to the cause(s)                |
|                | To the within 2 To the comple   | Me            | 29b. Signature and title of certifier  |  | 29c. License number  | 29d. E   | Date signed (Month, Day, Year)   |
|                |   |               | · show-  | END M.   | D27577   | 4  | 18/10  |
| 2              | 2   |               |  | completed cause of death (Item 23a) (Typ   | 3001 Hospital Dr.  | Chevert  | 4, MD 20785  |
|                | Sta<br>Registr  |               | 31. Date filed (Month, Day, Year) APR 1 2 2010   | 32. Registrer's Signature  | ,  | <del>,</del>                                   |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 4/13/1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 X M 2 □ F Days 53 MD 218-46-1100 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Millington Kent 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21651 29520 River Road USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farming 12 Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Grant Bateman Mary Stevenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary S. Bateman/mother 211 Mangum Dr. Bear, DE 19701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crumpton Cemetery 4/9/10 Crumpton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature yuneral Service Licensee Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington, MD 21651 Sar was lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ilure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1, Enter to shock, or heart Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of); 23d. Date of delivery Month Day Year

Physician /Medical Examiner

burial-tra

physician the as

signed by

has

Director: After this certificate

death. after

within 24 hours a

completely filled in by the funeral

Medical

To the Hospital or Attending

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funeral

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Completed

Be

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**Funeral** 

**Director** 

28a-f shov notified at

ō

ral", or items 23a o Examiner must be

"natural"

f other than " alth and Mental Hygiene.
27 is marked other than 's traumatic event, the Me

Health tem 27 i

Department of H Important: If ite any injury or ot once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Be Completed by Certification: To

| t | Gequentially list conditions,<br>any, leading to immediate<br>cause. Enter Underlying<br>cause (Disease or injury<br>hat initiated events<br>esulting in death) Last | b. Due to (or as a consecutive of the consecutive o |                             | · .                                      |  |
|---|--|--|-----------------------------|--|--|
|   | F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown   | 23c. If yes, outcome of pregr<br>1  Live birth 2  Fet<br>4  Pregnant at time of 9  | al death 3 🗌 Ectopic p      |  |  |
| F | Part II. Other significant conditions of   | ontributing to death but not re  | sulting in the underlying o | cause given in Part I.                   | 23e. Did tobacco   |
| - |  |  |                             |  | 24a. Was an autopsy performed? 1 \( \sum \text{ Yes}  2 \sum \text{ N} |
| 2 | <ol><li>Was case referred to medical examiner?</li></ol>   |  |                             |  | eath (Check only one)  |
|   | 1 Yes 2 No   | Hospital: Inpatient 2  | ER/Outpatient 3 DO          | A Other: 4 □ Nursing                     | Home 5 Residence   |
| 2 | 7. Manner of Death 1   |  | 28b. Time of Injury M       | 8c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No | 28d. Describe how inju   |
|   | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of injury - At h  |                             | office                                   | 28f. Location (Street a  |

| 23e. Did tobacco use contribute to the cause of death?   |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|
| 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown  |  |  |  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No |  |  |  |  |  |  |  |  |  |  |
| heck only one)   |  |  |  |  |  |  |  |  |  |  |
| 5 Residence 6 Other (Specify)  |  |  |  |  |  |  |  |  |  |  |
| I. Describe how injury occurred  |  |  |  |  |  |  |  |  |  |  |
| Location (Street and Number or Rural Route Number  |  |  |  |  |  |  |  |  |  |  |

|     | 0116)                              |
|-----|------------------------------------|
| 29b | . Signature and title of gertifier |
|     | > faller MI                        |
| 00  | Name and address of names who      |

29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

State

ar 31. Date filed (Month, Day, Year)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. 47,547,547,641, Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** FRIN Bluch 07 2010 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BrHinare MEDICAL Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 F -94-9696 3/1970 D.C. Director 01 Usual Residence of Decedent 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show traumatic event, the Medical Even timer must be multiped at 1X Yes 21 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 419 Calvin Avenue 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, I'm Mar Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Debra Blush ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Blush/Mother 11970 Lime Kiln Road, Fulton, MD 20759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State April 8, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASIANIC WELANDURT eton disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 □Yes 2 No P.0. 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2,5 Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 □N 2 ER/Outpatient 3 DOA 1 mpatient this Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? To the Hospital or Attending Phenitin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COX BA Homore 5 Greene 31. Date filed (Month, Day, Year) APR 0 9 2010 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month APRIL 2010 3:05 A JUDSON THOMAS BENNETT M Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Country) OHIO Days Hours Min. (Month, Day, Yea **Director** 271-28-9492 1932 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ty₽ Yes 2 ☐ No PRINCE GEORGE'S HYATTSVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3421 #204 20784 55th AVE. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 XMarried nd Mental Hygiene. marked other than "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MECHANICAL ENGINEER NEW PORT NEWS SHIP YARD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o THEODORE BENNETT **GWENDOLYN** ANNA SILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a JANET LAVONNE BENNETT/WIFE 55th AVE. #204, HYATTSVILLE, MD. 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 CCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 4-8-2010 RIVERDALE, MD. 21. Signature of Funeral Service Gensee 22. Name and Address of Eacility
CHAMBERS FUNERAL HOME & CREMATORIUM, P. A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner PANCYTOPENIA YEARS Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed 7 YEARS MULTIPLE MYELOMA Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: 1 XInpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital Division

Registrar

31. Date filed (Month, Day, Year) 0.9 2010

ESHO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

CHEVERLY,

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3001 HOSPITAL DR.,

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 6, 2010 Philip Bolten 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 17, 1924 1 **№** M 2 🗆 F Months Days Hours New York 86 **Director** 118-18-8914 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10202 Kindly Court 20886 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc X Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Audio/Video Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Bolten Edith Rochlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Bolten / Son 315 Tucker St., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of April ate 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 Donation 5 Dotter (Specify) Resthaven Crematory Frederick, Maryland 2010 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Fune lice Licens 23a, Part 1. Enter the disease Part 1. Enter the disease, or comshock, or heart failure. List only of cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death immediate Cause (Final Ph, sician/ disease or condition resulting in death) Ischemic Bowel Disease weeks Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physiclan and defeached for use as the burial-transit Cause (Disease or imjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical んっ, 04/06/10 | Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred work? 1 🗆 Yes 2 🗀 No injury 1 🛛 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Fertiliying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and due to the cause(s) and manner as allaled. (Check 24 within 2 To the I 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D 21115 April 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Lee R. Pennington, M.D. 10215 Fernwood Rd., Ste. 100A, Bethesda, MD 20817 32. Registur's Signature 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 10:45 MA Barbara Jean Biddinger 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 9. Birthplace (State or Foreign Country) Louisiana If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Y Days 1 M 2 X F Hours Yrs. **Director** 437-52-5309 70 Oct. Usual Residence of Decedent 28a-f show 10b. County 10a. State "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26904 Howard Chapel Drive 20872 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or ? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working 2 should be filed within 72 th and Mental Hygiene. Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) 12 School Bus Driver Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ John Vincent Ferrara, Sr. Annabelle Edna Thorne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau 26904 Howard Chapel Drive, Damascus, Maryland Frank Everett Biddinger, husb. 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burlal 2 X Cremation 3 Removal from State Donation 5 Other (Specify) Alexandria, Virginia Metropolitan Crematory 4/8/2010 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part . Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or h, art failure. List only one cause on each live. Immediat Caus (Final disease or contion resulting in death) Onset and Death Physician/ Preumonia Medical Due to (or as a consequence of): Examiner Acrite Disseel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami COPD -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnap 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Month Day Year the g 🗌 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 21 A 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No ieral Director: A filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month. Day, Year)

Memoral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death elson DOD 4c. County of Death name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Jan • 29 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 169-38-5439 50 Penna. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 No Penna. Franklin Greencastle 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 352 East Grant St. 17225 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Executive Of Operations Health Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald E. Barnhart Joan Hager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Barnhart/Wife 352 East Grant St. Greencastle, Pa. 17225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 4/21/10 Greencastle, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc.
45 S. Carlisle St. Greencastle, Pa. 21. Signature of Funeral Service Licensee . Martin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -auhamia Middel disease or condition

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f sho Examiner must be notified at

"natural",

the Medical

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.

Director

Funeral

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Completed

Be

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death with the Marylan or 28a-f show

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Be Completed by ၉ Certification: Medical

| resulting in death)   | due to (or as a consec   | quence of):                 |                        |                                 |                           |  |  |
|---|--|-----------------------------|------------------------|---------------------------------|---------------------------|--|--|
| Sequentially list conditions, if any, leading to an incident cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or as a nonsex  |                             | +                      |                                 |                           |  |  |
| resulting in death) Last  | Due to (or as a consec   | quence of):                 |                        |                                 |                           |  |  |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of pregn 1  Live birth 2 Fet 4  Pregnant at time of 6             | al death 3 - Ectopic pre    |                        |                                 | 23d. Date of del<br>Month | ivery<br>Day Year                                |  |
| Part II. Other significant conditions of  | ontributing to death but not re  | sulting in the underlying c | ause given in Part I.  |                                 | 1                         | o the cause of death?                            |  |
|   |  | <u> </u>                    |                        | 24a. Was an autopsy performed?  | prior to death?           | ntopsy findings available completion of cause of |  |
| 25. Was case referred to medical  |  |                             | 26. Place of De        | ath (Check only one)            |                           |  |  |
| examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital: 1 Inpatient 2  | ER/Outpatient 3 DOA         | Other: 4 - Nursing I   | Home 5 Residence                | 6 Other (Spec             | cify)  |  |
| 27. Manner of Death 1   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of lnjury M       | 28d. Describe how inju | d. Describe how injury occurred |                           |  |  |
| 3 Suicide 6 Could not b 4 Homicide determined   | e 28e. Place of injury - At h<br>building, etc. (Specia                                | nd Number or R              | ural Route Number,     |                                 |                           |  |  |
|   | ysician: To the best of my kno<br>niner: On the basis of examina<br>and manner stated. |                             |                        |                                 |                           |  |  |
| col Cinnet and title of a stiff a   |  |                             |                        | 00:1.0                          | to the state of the sale  | 2 1/ 1   |  |

600 North Wolfe St, Baltimore, MD, 21287

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Registrar

State

31. Date filed (Month, Day, Year)

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n 24 hours after death.

e Funeral Director: Aft bletely filled in by the fu

within 24 hou

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the Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KONCEMAN

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month Day **Physician** James Jerome Brailer 18:20 March 27, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Regional Medical Center Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Days Min Yrs. Director 212-24-1396 October 21, 1927 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 Yes 2 □ No items 23a or 28a-f sh Director Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Washington Street U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M/es 2 □ No Korean If fes, Give Year or Dates: Con fic Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No 3 Widowed 4 Divorced conflict White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) purchasing department aith and Mental Hygi 27 is marked other r traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be မ Francis Jerome Brailer Alma Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau Patricia Cain Brailer 21532-9 Washington Street Frostburg Maryland 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) March 31, 2010 Cumberland Maryland **Cumberland Crematory** 22. Name and Address of Facility Signature of Funeral Service Licenses Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a va consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) <u>Р</u> 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 🗆 No s after deau...
ral Director: After this co...
ral in by the funeral director, pe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier March 28, 2010 MD 21502

Registrar

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200 GleNN St. Saite 302 Cumberland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rreva 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                   |   |                | 1 - For Amend Items 23   | ate of Marylan   | . <mark>028<u>Де</u>ра</mark> | rtment of                              | 1963th 037/2                              | 462691 dan        | gjene                     |  |    |  |  |  |  |
|-------------------|---|----------------|--|--|-------------------------------|--|---|-------------------|---------------------------|--|----|--|--|--|--|
|                   |   |                | Registrar  1. Decedent's Name (First, Middle, Last)  |  |                               | inicate or                             | Deain                                     | 2. Date of Dea    | - 21                      | 3. Time of Death   | 5  |  |  |  |  |
|                   | Physici   |                | Joseph Nathan Brown  |  |                               |  |   | Month<br>March 3  | ,                         | 3:44 p M   | 1  |  |  |  |  |
| 1                 | /Medio  |                | 4a. Facility Name (If not institution, give stree  | t and number)  | Т                             | 4b. City, Town, o                      | or Location of Deatl                      |                   | 4c. County o              |  |    |  |  |  |  |
| ,                 | LXaiiiii  |                | Calvert Memorial Hosp  | ital   |                               | Prince Fr                              | rederick                                  |                   | Calve                     | rt   |    |  |  |  |  |
|                   | Funeral   |                | Social Security Number 6. Sex  | 7. Age (In yrs.  | last birthday)                |  | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Birt   | h                         | Birthplace (State or Foreig Country)                                       | ın |  |  |  |  |
|                   | Director  |                | 579-54-2267 1ÆM  |  | 67 Yrs.                       | World Days                             | Tiodio Isimi                              | May 10,           |                           | DC   |    |  |  |  |  |
|                   | and w   |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. Cit   | ty, Town or Loc               | cation                                 |   |                   |                           | 10d. Inside City Limits  | s  |  |  |  |  |
|                   | Maryll<br>f sho   | ō              | MD Cobject   |  |                               |  |   |                   |                           | 1 ☐ Yes 2 X No   |    |  |  |  |  |
|                   | the 1   | Director       | MD Calvert  10e. Street and Number   |  | wings                         | 10f. Zip Code                          |   |                   | 10g. Citizen of W         | hat Country?   |    |  |  |  |  |
|                   | 3a or   |                | 650 Good Shepherd Wa   | av   |                               | 20736                                  |   |                   | USA                       |  |    |  |  |  |  |
|                   | death   | Funeral        | 11. Marital Status 12. V   | Vas Decedent Ever in U.  | .S. 13. V                     | Vas Decedent of                        | Hispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No- | 14. Race                  | - American Indian,   |    |  |  |  |  |
| 21215-0036        | 72 hours after death with the Maryland<br>"natural", or Items 23a or 28a-f show<br>digal Evaluting to providing at                | by             | 1 Never Married 2 🗷 Married 1  | ☐Yes 2 MNo<br>Yes, Give<br>ear or Dates:   |                               | Yes 2 No                               | Specify:                                  | o riidan, etc.)   | Specify:                  | s, White, etc.  Black  |    |  |  |  |  |
| 2-0               | 72 ho   | Completed      | 15. Decedent's Education (Specify only highest grade con   | n nolated)   |                               | lent's Usual Occup                     | oation<br>during most of wor              | kina              | 16b. Kind of Bus          |  |    |  |  |  |  |
| 2                 | I within 72 ho<br>giene.<br>r than "natu<br>the Medical   | nple           |  | college (1-4or 5+)   | life. L                       | OO NOT use retire                      | d)  | King              |                           |  |    |  |  |  |  |
|                   | e filed wi<br>al Hygier<br>other th   |                |  | 5+   |                               | Pa                                     | stor                                      |                   | Clergy                    | ,  | _  |  |  |  |  |
| and<br>m          | e g the D   | æ              | 17. Father's Name (First, Middle, Last)  |  |                               |  |   |                   | Maiden Surname            | •)   |    |  |  |  |  |
| <u> </u>          | ⊇ ≥ # #   | မ              | Henry H. Brown Sr.   | 1(   | 405 14-95                     |  |   | ee Onnibit        |                           | Charles Win Condo  |    |  |  |  |  |
| Maryland          | d 2 sho th and 7 Is ma trauma   |                | 19a. Informant's Name/Relationship (Type. F  Pearlie M. Brown  | · ·  |                               |  | and Number or Ru                          |                   |                           | , ,  |    |  |  |  |  |
|                   | s 1 and 2<br>of Health a<br>Item 27 is<br>other trai  |                | 20a. Method of Disposition   |  |                               | sition (Name of<br>natory or other pla | epherd Way                                | Date              |                           | Oity or Town, State  |    |  |  |  |  |
| <u>o</u>          | Pages<br>nent of<br>int: if lts<br>iry or o   |                | 1⊠Burial 2 ☐ Cremation 3 ☐ Remo  | vai from State   |                               |  | i   | 0.0040            | D-i                       | deside MD  |    |  |  |  |  |
| Baltimore,        | 그 두 약 글   |                | 21. Signature of Funeral Service Licensee /  | 4 □ Donation 5 □ Other (Specify) Greater Bible Way Church April 9, 2010   Prince Frederick, MD  Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. |                               |  |   |                   |                           |  |    |  |  |  |  |
| ä                 | permi<br>Depar<br>Impor<br>any ir   | k II           | 1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Service Licensee Sewell Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funeral Home, P.A.  1. Signature of Funera |  |                               |  |   |                   |                           |  |    |  |  |  |  |
|                   |   |                |  |  |                               |  |   |                   |                           |  |    |  |  |  |  |
| $C_{i}^{s}$       | Physician   |                | shock, or heart failure. List only one cause on each line  Complications of Subdural Hematoma  disease or condition  a  Complications of Subdural Hematoma   |  |                               |  |   |                   |                           |  |    |  |  |  |  |
|                   | Physician<br>/Medical<br>Examiner   |                | resulting in death)  | Due to (or as a conseq   |                               |  |   |                   |                           | 7,700129   |    |  |  |  |  |
|                   |   |                |  | THELO SCORE  |                               | 1.2310114                              | COURS ?                                   | ) J - 30          |                           | 4=40   |    |  |  |  |  |
|                   | ed<br>sit   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a conseq   | uence of):                    |  |   | IA                | LOAV WA. MEDICAL EXAMINER |  |    |  |  |  |  |
|                   | icate be executed<br>physician and<br>the burial-transit  | xan            | that initiated events c resulting in death) Last   | Due to (or as a consequence  | uence of):                    |  | 0   | Je tro            | - TUCAL EXAMINE           | R  | _  |  |  |  |  |
| 68760,            | e be e<br>siciar<br>burit   | dical E        |  |  |                               |  | Co  | ON APPROVED BY    | WEDIO                     |  |    |  |  |  |  |
|                   |   | 1 00 1         | u  |  |                               |  | CERTIFICA                                 | Mil.              |                           |  | _  |  |  |  |  |
| Вох               | eath certific<br>attending p<br>for use as  | N/             | 23b. was decedent pregnant   | yes, outcome of pregna   |                               | l Catania aragnan                      |   |                   |                           | e of delivery  |    |  |  |  |  |
| B.                | that the death certified by the attending detached for use as   | Physician/M    | 1 Dyes 2 No  | ☐ Pregnant at time of o  |                               | Ectopic pregnand<br>Other (specify) _  | зу  |                   | Mon                       | nth Day Year   |    |  |  |  |  |
| P.0               | that the dened by the a   | h.             | 9 Li Unknown   |  |                               |  |   |                   |                           |  |    |  |  |  |  |
| Ś                 | w requires that<br>s been signed I<br>should be det   | by             | Part II. Other significant conditions contribu   | ting to death but not resi   |                               |  |   |                   |                           | bute to the cause of death?  3 ☐ Probably 4 ☐ Unknown                      | m  |  |  |  |  |
| 0                 | law requires<br>as been sign<br>2 should be   | Completed      | HAT SUBJURAT   | ertensive A  | -                             | a SETS                                 | MELLAU)                                   | 101               | 74                        |  | _  |  |  |  |  |
| of Vital Records, | e la<br>ha:<br>e 2  | 현              | <del>                                      </del>  |  | CHCLOS                        | LICIOLIC                               | -   | 24a. Was          | sy pi                     | Vere autopsy findings available<br>rior to completion of cause of<br>eath? |    |  |  |  |  |
| a                 | ician: The l<br>certificate ha<br>ector, page   |                | Cardiovascular Dis   | sease  |                               |  |   | 1 □ Yes           |                           | Yes 2 No   |    |  |  |  |  |
| <u>X</u>          | ding Physician:<br>h.<br>After this certifics<br>funeral director, p  | Be             | 25. Was case referred to medical examiner?   | tal:   | - Lin                         | Ott                                    | oor:                                      | ath (Check only o |                           |  |    |  |  |  |  |
| of                | Physic this aral di   | 7: To          | A 103 2 100  | a Date of Injury   | 28b. Time of                  | t 3 DOA                                | 4 LI Nursing F                            | T                 | dence 6 Othe              |  | -  |  |  |  |  |
| on                | th.<br>th.<br>: Afte  | 텵              | 1 ☐ Natural 5 ☐ Pending<br>2 <b>X</b> Accident investigation   | (Month, Day, Year)<br>1272072008   | Injury                        | 28c. Inju<br>Wor<br>M 1 [              | rk?<br>]Yes 2█No                          |                   | in bathr                  |  |    |  |  |  |  |
| Division          | Atter   | ifica          | 2 Could not be   | Be. Place of Injury - At he building, etc. (Specif   | Unknow<br>ome, farm, stre     |  |   | 28f. Location (S  | Street and Numbe          | er or Rural Route Number,  |    |  |  |  |  |
| Ö                 | tal or<br>s afte<br>al Dir<br>ed in   | Certification: | 4 Tromicide  | Hotel  | 9/                            |  |   | Cable B           | Beach, Nas                | t Bay Street @<br>ssau, Bahamas  | !  |  |  |  |  |
|                   | To the Hospital or Attending P within 24 hours after death.  To the Funeral Director. After t completely filled in by the funeral |                | 29a. Certifier 1 Certifying Physicia 2 Medical Examiner:   | On the basis of examina  |                               |  |   |                   |                           |  |    |  |  |  |  |
|                   | thin 2<br>thin 2<br>the i   | Medical        |  | and manner stated.   |                               | 29c. Licens                            |   |                   |                           | (Month, Day, Year)   | _  |  |  |  |  |
|                   | <b>5</b> ≥ <b>6</b> ⊗   |                | 295. Signature and title of certifier  | 1  |                               |  |   |                   | A Po                      | 1  |    |  |  |  |  |
|                   |   |                | Copy It Charge   | (1)  | - 00a\ /T                     | D2 (                                   | 6358                                      |                   | prieil                    | 1,2010   |    |  |  |  |  |
| JA                | w 3   |                | 30. Name and address of person who comple  | ted cause of death (Item   | 11 23a) (1ype, 1              | Print)  PRINCE                         | = FAF                                     | DERICI            | M) -                      | 20678  |    |  |  |  |  |
|                   | Sta   | te             | 31. Date filed (Month. Day, Year)  | 32. Registrar Signa  | ature                         | 1 the contract                         | 1 1014                                    | - COLCE           | , " " ) " (               | 20010  |    |  |  |  |  |
|                   | Registr   |                | APR 072  | nin /  | . 6                           | 6                                      | b.  |                   |                           |  |    |  |  |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 100RC Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner Montgomer omn 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 **M** 2 □ F Hours Warren, **Director** Ohio Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 28a-f Maryland 1 X Yes 2 No Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
sant. If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b 9510 49th Place 20740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 N Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Diesel Mechanic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert William Burns Mildred Louise Seitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David P. Burns / Brother 9510 49th Place, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department o Important: If any injury or 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 4/15/2010 Adelphi, Maryland George Washington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Fogus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition Medical resulting in death) Examiner Securitally list outditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to for as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 24 hours after death.

Funeral Director: After this certificate has been signed by ated filled in by the funeral director, page 2 should be detacled. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🔀 🕿 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c, License number 29d, Date signed (Month, Day, Year)

GL & State

Registrar

DHMH 17 Rev 7/2009

210

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

10-02797 Robert Coleman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Robert Coleman   |                | 1- For State   | State                 | e of Maryla                          |  |                                 |             | Health and<br>Death                          | l Menta             | al Hygiene                       | Reg. No                             | 201              | 0                     | 12698                                     |
|--|----------------|--|-----------------------|--------------------------------------|--|---------------------------------|-------------|--|---------------------|----------------------------------|-------------------------------------|------------------|-----------------------|---|
| Physicia   |                | Registrar  1. Decedent's Name (Fir                       | rst, Middle, L        | ast)                                 |  |                                 |             |  |                     | 2. Date of D                     | eath                                |                  | 3.                    | Time of Death                             |
| Medical Examin   | er             | Robert We  | sley (                | Coleman                              |  |                                 |             |  |                     | Month<br>April 8,                | 2010                                | Year             |                       | 1345 hrs                                  |
|  |                | 4a. Facility Name (if not                                |                       |                                      | mber)  |                                 | 4           | b. City, Town, or L                          |                     | Death                            |                                     | c. County of [   |                       |   |
|  |                | 311 Deep Land  |                       |                                      |  |                                 |             | Chestertown                                  |                     |                                  |                                     | Queen An         |                       |   |
| Funeral  |                | 5. Social Security Number                                |                       | Sex                                  | 7. Age (In   | yrs. last bii                   | thday)      | If Under 1 Year<br>Months Days               | If Under 2<br>Hours | 24Hrs. 8. Date of<br>Min.        | Birth(MN                            | NDD/YYYY) 9<br>F | 9. Birthpl:<br>oreign | ace (State or                             |
| Director   | Į              | 223-64-150   | 9 1                   | XM 2 F                               | 6  | 1                               | Yrs.        | World Bays                                   | riodis              |                                  | /194                                | 8                | Countr                | OH OH                                     |
| è  | ŀ              | Usual Residence of Dec                                   | County                |                                      | 1100   | City, Town                      | or Location | 20   |                     |                                  |                                     |                  | 110                   | d. Inside City Limits                     |
| W 48   |                |  | •                     |                                      |  | •                               |             |  |                     |                                  |                                     |                  |                       | Yes 2 XNo                                 |
| ryland<br>a-f sh   | 흱              | MD Q   | ueen <i>l</i>         | Anne's                               |  | Chest                           | erto        | √n<br>10f. Zip Code                          |                     |                                  | 10a Ci                              | tizen of What    |                       |   |
| ith the Maryland<br>23a or 28a-f show any<br>notified at once.   | Director       | 311 Deep   | Landir                | o Rd.                                |  |                                 |             | 21620  |                     |                                  | 10g. 01                             | USA              | Country               |   |
| vith th  |                | 11. Marital Status                                       |                       | 12. Was Dec                          | edent Ever   | in U.S.                         | 13. Was     |  | anic Origin         | ? ( Specify Yes or               | No-                                 |                  | American              | Indian, Black,                            |
| 11. Marital Status 1 Never Married 2 Married 7 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No  |                |  |                       |                                      |  |                                 |             | White, e                                     |                     |                                  |                                     |                  |                       |   |
| 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: W  |                |  |                       |                                      |  |                                 |             | hite   | 2                   |                                  |                                     |                  |                       |   |
| ours a   | ğ<br>Q         | 15. Decedent's Educati                                   | ion (Specify          | only highest grad                    | le complete  | ed) 16a.                        |             | 's Usual Occupation                          |                     |                                  | 16b.                                | Kind of Busin    | ess/Indu              | istry                                     |
| 6 n 72 h   | jet            | Elementary/Secondar                                      | y (0-12)              | College (1                           | -4 or 5+)  |                                 | -           |  |                     | ,                                |                                     |                  |                       |   |
| 5-003<br>led withi<br>Tygiene.<br>other th   | Completed      | 7<br>17. Father's Name (First                            | Middle Le             | -43                                  |  | Ŀ                               | xcava       | ation Cor                                    |                     | Name (First, Middle              |                                     | Constru          | ctic                  | on  |
| 21215-0036 Juld be filed within 72 hours after Mental Hygiene, marked other than "natural", event, the Medical Examiner  | To Be          | Walter Wil   |                       | ,                                    |  |                                 |             |  |                     | name (First, Middle<br>ah Elizah |                                     |                  |                       |   |
| 2121<br>uld be fi<br>Mental I<br>marked  |                | 19a. Informant's Name/R                                  |                       |                                      |  | 19                              | b. Mailing  | Address (Street                              |                     | er or Rural Route N              |                                     |                  | State, Zir            | c Code)                                   |
| MD and 2 sho alth and 2 sho alth and sm 27 is  |                | Carol L. P   | letzei                | /Fiance                              | e  |                                 | 311 1       | Deep Land                                    | ling F              | Rd., Ches                        | tert                                | own, M           | D 21                  | 1620                                      |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once   | Ī              | 20a. Method of Disposition                               |                       |                                      |  |                                 |             | tion (Name of ceme                           |                     | Date                             |                                     | Location - Ci    |                       |   |
| Baltimore,<br>permit. Pages 1 ar<br>Department of Hei<br>Important: If ite   |                | 1 Burial 2 X C   |                       |                                      |  |                                 | •           | e Cremati                                    | ion /               | 1/12/10                          |                                     | evensv           | .i112                 | a MT)                                     |
| altir<br>mit. ]<br>partm<br>ports<br>ury o   | t              | 21. Signature of Funeral                                 |                       |                                      | 1  | onesa                           | 22. N       | ame and Address of                           | of Facility         | ein & Ne                         | 150                                 | T                | _ 1 7                 | J   |
| E.F. C. B.   |                | Kuch   | X.X                   | lelfe                                | l-i-   | >                               | 1 130       | J Speer R                                    | ka. Ur              | iestertow                        | n. M                                | W 2162           | :U                    | iome                                      |
| Physician  |                | 23a. Part I. Enter the dis-<br>failure. List only on     | ease, or con          | nplications that ca                  | aused the d  | eath. Do n                      | ot enter th | e mode of dying, s                           | uch as card         | diac or respiratory              | arrest, sh                          | ock, or heart    | A                     | Approximate Interval<br>Between Onset and |
| Examiner   | 1              | Immediate Cause (Final                                   | disease               |                                      |  |                                 | toxic       | ation (m                                     | ethad               | one, quet                        | :iap:                               | ine)             |                       | Death                                     |
|  | -              | or condition resulting in                                |                       | Due to (or as a                      | consequer  | ice of):                        |             |  |                     |                                  |                                     |                  |                       |   |
|  | اةِ            | Sequentially list condition if any, leading to immediate | iate                  | Due to (or as a                      | consequer  | ice of):                        |             |  |                     |                                  |                                     |                  |                       |   |
|  | Examiner       | cause. Enter Underlying (Disease or injury that in       | itiated               | Due to (or as a                      | 202227122  | of):                            |             |  |                     |                                  |                                     |                  | _                     |   |
| ansit  | ЩÏ             | events resulting in death                                |                       | d.                                   | conseque   | ice oi).                        |             |  |                     |                                  |                                     |                  |                       |   |
| Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and represent property filled in by the funeral director, page 2 should be detached for use as the burial - transit   | edical         | X UNPENDED   |                       |                                      | DIT 2  | 7 20                            |             | erm,E g90                                    | 02 5/               | 6/10 mm                          |                                     |                  |                       |   |
| '60,<br>ate be ex<br>ohysician<br>e burial   |                | IF FEMALE:   |                       | 23c. If yes, o                       | DILL 2   | ノ <sub>ッ</sub> ∠改さ<br>pregnancy | 1-r,p       | erm, E gy                                    | 03 5/6              | 6/1U TT                          | 23                                  | d. Date of de    | livery                |   |
| 687<br>ertific<br>ding 1   | sician/N       | 23b. Was decedent pregr<br>past 12 months?               | nant in the           | 1 Live b                             |  |                                 | 2 Feta      | al death 3                                   | Ectopic pr          | regnancy                         |                                     | Month            | Day                   | Year                                      |
| that the death certificat red by the attending phedeached for use as the   | Sic            | 1 Yes 2 No 9   | Unknov                | - L                                  | antattime  | or death                        | 5 Oth       | er (Specify)                                 |                     |                                  |                                     |                  |                       |   |
| the d  | Ä              | Part II. Other significan                                | t conditions          |                                      |  | not resultin                    | g in the ur | nderlying cause giv                          | en in Part I        | . 23e. Did                       | tobacco                             | use contribut    | te to the             | cause of death?                           |
| P.O.   | <u></u>        | Hyperten   | sive a                | atherosc                             | 1erot  | ic ca                           | ardio       | vascular                                     | disea               | ase 1                            | 'es 2 [                             | No 3             | Probably              | y 4 🗸 Unknown                             |
| Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sten in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director or a should be s | Completed      |  |                       |                                      |  |                                 |             |  |                     | 24a. Wa                          |                                     |                  |                       | sy findings available                     |
| COI<br>e law<br>e has l  | 副              | obesity<br>Chronic a                                     | lasha                 | 1                                    |  |                                 |             |  |                     | per                              | opsy<br>formed?                     | deat             | th?                   | oletion of cause of                       |
| ian Rec  |                | 25. Was case referred to                                 |                       | I abuse                              |  |                                 |             | 26 Place o                                   | of Death (Ch        | neck only one)                   | 21                                  | 1 2              | Yes                   | 2 No                                      |
| Vital F<br>hysician:<br>this certifi   | <u>~</u>       | examiner?  |                       | Hospital:                            | npatient 2   | ER/0                            | utpatient   |  | 45                  |                                  | Resid                               | ence 6 🗸         | Other: So             | ene                                       |
| n of \ding Phy   | 읽              | 27. Manner of Death                                      | NO                    | 28a. Date                            | of Injury  | <del></del> _                   | Time of In  |  |                     |                                  | e how in                            | jury occurred    |                       |   |
| on<br>endin<br>ath.  | 희              | 1 Natural 5  | Pending               | D1 //                                | Day,Year)  | Ed                              | 1:00        | 1 Ye   | s 2 X No            | unk                              |                                     |                  |                       |   |
| Visi<br>or Att<br>Rer de<br>Direct<br>in by  | <u>≅</u>       | 2 Accident 3 Suicide 6 X                                 | Investiga<br>Could no | 28e Place                            |  |                                 |             | , factory, office bui                        | ilding, etc.        | 28f. Location                    | (Street                             | and Number of    | r Rural F             | Route Number, City<br>anding Rd           |
| Divisior Hospital or Attend 24 hours after death 25 Funeral Director: stely filled in by the   | Certification: | 4 Homicide   | determin              |                                      | Resi   | dence                           | 2           |  |                     | Cheste                           | rtov                                | vn, MD           | sh re                 | anding Ku                                 |
| e Hos<br>24 ho<br>e Fun<br>etely   |                | 29a. Certifier 1 Certi                                   | ifying Physi          | cian: To the bes                     | of my know   | wledge, de                      | ath occurr  | ed at the time, date                         | e and place         | , and due to the ca              | use(s) a                            | nd manner as     | stated.               |   |
| To the Hos within 24 h To the Fur completely   | Medical        |  |                       | er: On the basis of<br>and manner si | examinati<br>ated  | on and/or i                     | nvestigatio |  |                     | red at the time, da              |                                     |                  |                       |   |
|  | 2              | 29b. Signature and title of                              | n certifier           | 11 1                                 | And the same of th |                                 |             | 29c. License                                 |                     |                                  | 29d. Date signed (Month, Day, Year) |                  |                       |   |
| 5  |                | aplu   | Biss                  | 16/1/1                               | 3  |                                 |             | O.C.M  | ı. <b>⊆</b> .       |                                  | Api                                 | ril 10, 2010     | ,<br>                 |   |
| ms   |                | <ol> <li>Name and address of Melissa Brassel</li> </ol>  |                       | o compléted caus<br>Assistant Me     |  |                                 | 111 P       | enn Street, Ba                               | ltimore             | MD 21201                         |                                     |                  |                       |   |
| Sta  | te             |  |                       | L32. Re                              | gi trar's Sig  |                                 | E E         | a state pa                                   |                     |                                  |                                     | -                |                       |   |
| Registr  | ar             | 31. Date filed (Month,                                   | LW 7 3                | 2010                                 | Orace  | ار ب                            | 1.          | S. A. S. |                     |                                  |                                     |                  |                       |   |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day April 12,2010 Year 6:15 <sup>Ри</sup> **Physician** George Jacob Cline Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 219 North Cannon Avenue Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Hours | Min. August 5, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Months 1 X M 2 □ F 215-14-1526 Maryland 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23 a or 28a-f show any injury or other traumatic event, In Which Evanting Trust be notified at agine. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 North Cannon Avenue 21740 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🛣 No Specify. 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 5 Building Supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Cline 2 Rosa Mav McKee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Cline 124 North Edgewood Drive, Hagerstown, Md. 21742 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Rose Hill Cemetery 04-15-10 Hagerstown, Maryland 21. Signature of Funeral Service License Andrew K. Coffman Funeral Home, Inc. R. hoel & 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final one325 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): D. Winav Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine lwome Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 20510h 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 000 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

Examiner Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, death.

attending physician and for use as the burial-tran

signed by the a d be detached for

this certificate

After thi funeral of

Director: d in by the

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

within 24 hours aft To the Funeral Di completely filled in WH-4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Hagerstown, Maryland 21740 Correces MD 1124 Opal Court, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

APR 1 4 2010

M.D.

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |                  | For<br>State<br>Registrar  |  |                 |                                      |                             |               | / Depa   |                       | Health and I   | All Copie<br>Mental Hy          |                  | 9   |                    | 12                                       | 700            |
|--|------------------|--|--|-----------------|--------------------------------------|-----------------------------|---------------|--|-----------------------|--|---------------------------------|------------------|---|--------------------|--|----------------|
| Diversities  |                  | 1. Decedent's Nam  | e (First, Middle   | , Last)         | -                                    |                             |               |  |                       |  | 2. Date of De                   | eath             |   |                    | 3. Time of                               | Death          |
| Physicia<br>Medio  |                  | Beth Elai  |  |                 |                                      |                             |               |  |                       |  | Month<br>April                  | $6, \frac{0}{2}$ | 010   | Year               | 6:50                                     | P <sup>M</sup> |
| Examin   | er               | 4a. Facility Name (if  | ,  |                 |                                      | ,                           |               |  |                       | or Location of Death   | 1                               | 1                | c. County o                                       |                    |  |                |
| Funcion  |                  | Montgomer 5. Social Security N   |  | ral<br>6. Sex   | Hospi                                |                             | n yrs. last l | hirthday)  | Olney If Under 1 Year | If Under 24 Hrs.   | ■ 8. Date of Bir                |                  | ontgo:  |                    | place (State or                          | Foreign        |
| Funeral<br>Director  |                  | 213-42-76  | 27   |                 | M 2 🕅 F                              | 7.7.igo (ii                 | 65            | Yrs. Months Days Hours Min. (Month, Day, Year) Aug. 19, 1944 |                       |  |                                 |                  |   | lich               | igan                                     | roreign        |
| ind<br>show<br>at  | or               | Usual Residence of<br>10a. State   | 10b. County  |                 |                                      | 10                          | Oc. City, To  | own or Loc   | ation                 |  |                                 |                  |   | T                  | 10d. Inside Cit                          | y Limits       |
| Aaryla<br>8a-f s<br>tified   | rect             | Maryland   | Montgo   | merv            | ,                                    | S                           | ilver         | Snr  | oring                 |  |                                 |                  |   |                    | 1 🗌 Yes                                  | 2 <b>∑</b> No  |
| the Na or 2  | Funeral Director | 10e. Street and Nur  |  |                 |                                      | 15.                         |               |  | 10f. Zip Code         |  |                                 | 10g. C           | itizen of W                                       | hat Cou            | ntry?                                    |                |
| h with   | nera             | 3443 Sout  | h Leis   |                 |                                      |                             |               | d  | 20906 USA             |  |                                 |                  |   |                    |  |                |
| r iten<br>iner r   |                  | 11. Marital Status   |  | - 1             | 2. Was Dece<br>Armed Fo              | orces?                      |               |  |                       | tispanic Origin? (Sp<br>an, Mexican, Puerto                            |                                 |                  | 14. Race - American Indian,<br>Black, White, etc. |                    |  |                |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | d by             | 1 ☐ Never Marr<br>3 ☐ Widowed  |  | iea             | 1 ☐ Yes<br>If Yes, Giv<br>Year or Da | 2 🔯 No<br>ve<br>ates.       |               | 1  | ☐ Yes 2 🛛 No          | Specify:   |                                 |                  | Specify:  | Whi                | te                                       |                |
| hour<br>natur  | olete            | /Sne   | 15. Deceden  |                 | cation                               |                             | 11            |  | ent's Usual Occu      |  | lina                            | 16b. l           | Kind of Bus                                       |                    |  |                |
| nin 72<br>ne.<br><b>than "</b><br>e Me   | Completed        | Elementary/Sec   |  | 37 Grade        | College (1                           | I-4 or 5+)                  |               | life. DC   | NOT use retired       | •  | unselor                         |                  |   |                    |  |                |
| d with   | BeC              | 17 Fother's Name (   | Eiret Middle I   | act)            |                                      | 5+                          | Μe            | ental  | <u>Health</u>         | & Addict:  |                                 |                  | pital<br>^  |                    |  |                |
| be file<br>antal F<br>ked o<br>c eve   | 70 E             | 17. Father's Name (First, Middle, Last)  Robert L. McClosky  Barbara Elaine Corner   |  |                 |                                      |                             |               |  |                       |  |                                 |                  |   |                    |  |                |
| nould<br>nd Me<br>s mar<br>umati   |                  | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State |  |                 |                                      |                             |               |  |                       |  |                                 |                  | ate. Zip (  | Code)              |  |                |
| d 2 sk<br>alth a<br>27 is<br>ertra   |                  | Robert C.  | McClo  | sky.            | brot                                 | her                         |               |  |                       |  |                                 |                  |   |                    | 0832                                     |                |
| of He<br>of He<br>of item<br>or othe   |                  | 20a. Method of Disc  | Da. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State |                 |                                      |                             |               |  |                       |  |                                 |                  |   |                    |  |                |
| . Page<br>iment<br>tant: I<br>tury o   |                  | 4 Donation   | 5 Dothe  | oecify)         | SHOVAR                               | Nate                        |               | polit  | an Crem               | atory 4/7  |                                 |                  |   |                    | Virgin                                   |                |
| Depart<br>Mpor<br>Iny in   |                  | 21. Signature of Eur   | neral Service Li   | icensee         | 3                                    | 0 1 -                       |               |  |                       | ess of Facility Mo   |                                 |                  |   |                    |  | Home           |
| TD = 60  | -                | 23a Bort 1 Entor t   | the disease or   | complia         | ations that                          | caused the                  | o doath D     |  |                       | e Road, I  |                                 |                  | агута   | na                 | 20872                                    |                |
|  |                  | shock, or he as  | rt failure. List o   | nly one         | cause on ea                          | ach line.                   |               |  |                       | , ,  |                                 |                  |   |                    | Approximate<br>Interval Betwoonset and D | veen           |
| Physician/<br>Medical  |                  | disease or con litio<br>resulting in death)  |  | <b>a</b> .      | Due to                               | for as a co                 | nsequenc      | e of:  | un:                   | THOUS  | MA                              |                  |   | - 1                | 701                                      | 475            |
| Examiner   |                  | 0  | 1141   | Ι.              |                                      | n                           | RETO          | 1574   | nu n                  | NEAT   | ina                             | =1               |   |                    | YKA.                                     | RS             |
| _ +  | Examiner         | Sequentially list conditions, If any, leading to immediate  Due to (or as a consequence of).   |  |                 |                                      |                             |               |  |                       |  |                                 |                  |   |                    |  |                |
| be executed<br>sician and<br>burial-transit  | xan              | Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):                           |  |                 |                                      |                             |               |  |                       |  |                                 |                  |   |                    |  |                |
| oe exe<br>ician a<br>burial-   | cal E            | resulting in death) Last  Due to (or as a consequence of):   |  |                 |                                      |                             |               |  |                       |  |                                 |                  |   |                    |  |                |
| cate to physics the l  |                  |  |  | d.              |                                      |                             |               |  |                       |  |                                 |                  |   | _                  |  |                |
| eath certificate b<br>attending physi<br>I for use as the b  | Physician/Medi   | IF FEMALE:<br>23b. Was decedent  |  | 23              | c. If yes, out                       |                             |               | ath 2  | Ectopic pregnan       |  |                                 |                  | 23d. Date   | of deliv           | ery                                      |                |
| death  | sicia            | in the past 12 r   | <b>≥</b> No  |                 | 4 Preg                               | nant at tin                 |               |  | Other (specify)       | СУ   |                                 |                  | Mon   | th                 | Day Ye                                   | ear            |
| it the   | Phy              | 9 Unknown Part II. Other signif  |  | ne cont         |                                      |                             | not recultin  | a in the ur  | adortvina onuna a     | ivan in Port I   | Do. Did.                        |                  |   |                    | ne cause of de                           | -41-O          |
| es tha<br>signed<br>I be di  | d by             |  | ENAL   |                 | •                                    |                             | or resultin   | ig iii tile til  | idenying cause g      | iveirni raiti.   | 1                               |                  |   |                    | pably 4 🗆 t                              |                |
| requir<br>been should  | Completed by     | _//  | 7/1/   |                 | ,,,                                  |                             |               |  |                       |  | 24a. Was                        |                  |   |                    | psy findings a                           |                |
| e law<br>e has<br>ige 2 s  | ошо              |  |  |                 |                                      |                             |               |  |                       |  | auto                            | psy<br>ormed?    | pr<br>de  | ior to co<br>eath? | mpletion of ca                           |                |
| sician; The law certificate has birector, page 2 s   | Be C             | 25. Was case referre   | ed to medical  |                 |                                      |                             |               |  | 26. P                 | lace of Death (Chec  | 1 Yes                           | 2 N              | 0 1   | ∐ Yes_             | 2 No                                     |                |
| nysicia<br>iis cer<br>direct   | To B             | examiner?<br>1  Yes 2  | ₩No  | Но              | spital:                              | Inpatient                   | 2 🗆 ER/       | Outpatient   | t 3 □ DOA Oth         | or:  | ome 5 🗆 Resid                   | dence (          | 6 🗌 Other   | (Specify           | )  |                |
| ng Pł  |                  | 27. Manner of Death<br>1 Natural   | h<br>5 🗌 Pending   | 7               | 28a. Date<br>(Moni                   | of injury<br>th, Day, Ye    |               | Time of injury   | 28c. Inju             |  | 28d. Describe I                 | now injur        | y occurred  | i                  |  |                |
| ttendi<br>death<br>tor: A<br>the fu  | Certificate:     | 2 Accident 3 Suicide   | Investig   | ation           | 00 51                                | 61.1                        |               | Course other   |                       | Yes 2 No   |                                 | -                |   |                    |  |                |
| al or At<br>s after<br>il Direc<br>ed in by  | Cer              | 4 🗌 Homicide   | determi  |                 |                                      | of Injury -<br>ing, etc. (S |               | farm, stre   | et, factory, office   |  | 28f. Location (S<br>City or Tov |                  |   | or Rurai           | Route Numbe                              | ur,            |
| To the Hospital or Attending Physician; The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the    | Medical          | Check 2  | . ☐ Medical Ex   | <b>cam</b> ine: | : On the bas                         | sis of exam                 | nination and  | d/or investi   | gation, in my opini   | e, date and place, a<br>ion, death occurred a<br>ne time, date and pla | at the time, date a             | and place        | e, and due t                                      | to the ca          | use(s) and man                           | ner stated.    |
| To the vithin comp   | -                | 29b. Signature and   |  | 1               | /                                    |                             |               |  | 29c. Licens           | e number   |                                 | 29d. Da          | ite signed  | (Month, i          | Day, Year)                               |                |
|  |                  | 1 &  | ul/a   | 1               | 11                                   | 1                           | 2             |  |                       | 02594  | 7_                              | AY               | RIL   | 1,                 | 20/0                                     | )              |
| 12   |                  | 30. Name and addre   | / /  | he con          | pleted caus                          | se of death                 | (Item 23a     | a) (Type, Pr   | rint)                 | 02594<br>OUNT, SI  |                                 |                  |   |                    | 2  | 0832           |
| - 01-  |                  | 31. Date filed (Monti  | h, Day, Year)  | you             | 100 B                                | egistrar's                  | Signature     | Am   | 1000                  | OUNT, SI   | 11772 7                         | 200,             | DLA   | Ry                 | cus                                      |                |
| Stat   | е                | 222004 (11101111   | AGO  | 0               | BOND.                                | ogioundi Si                 | orginature    | E  | 1                     | 1  |                                 |                  |   | -                  |  |                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Crawford 4:01PM William Delos Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Cumberland 708 Louisiana Avenue 5. Social Security Number 9. Birthplace (State or Foreign Country) PA If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Sep 26. 1 □<sub>X</sub>M 2 □ F 201-12-3766 Director 85 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director Cumberland MD Allegany 1 XYes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21502 708 Louisiana Avenue USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give WW II 3 Widowed 4 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) General Vice President Railroad Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oft any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lovola (Wilt) Crawford Delos Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 708 Louisiana Avenue Cumberland MD 21502 Patricia Crawford daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 4/7/2010 MD Cumberland 4 Donation 5 Other (Specify) 21. Sig Ture of Funeral Sep 22. Name and Address of Full Peral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIONYOP disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has becompleted filled in butter. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier gustrano Jans / D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REPAMD 200 (PLENN ST 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Yvonne C. Clanton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Commen If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🖾 F Oct. 19 Months Min. Year) 983 Maryland Director 215-06-5967 26 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's Greenbelt Maryland 10f. Zip Code 10g. Citizen of What Country? Funeral 6003 Springhill Drive #201 20770 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 🗷 Never Married 2 🗆 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: African If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) 12th College (1-4 or 5+) Food Service Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Robert O. Clanton, Jr. Yvette Gilmore permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 3330 Curtis Drive #203 Suitland, Maryland Yvette Clanton/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 X Cremation 3 Removal from State Lee's Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Sign ture of Funeral Service Ligensee 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final odne Heart Diseas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ysician and e burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 4 Pregnant at time of death 1 Yes 2 No 9 Unknown ed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? þ Records, has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha To the Hospital or Attending Physician: The 1 Yes 2 No director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2- ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Division within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6  $\square$  Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Framiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

APR 0 9 2010

of Vital

| William Nelson (  |                | 1- For State  | or Print in B<br>e of Maryland   | / Depa                        |                                 | f Health ar  |   | lygiene                                 | gible.<br>20                           | 10 1270   |
|---|----------------|---|--|-------------------------------|---------------------------------|--|---|---|--|---|
| Physicia<br>Medical Exami   | an/            | Registrar  1. Decedent's Name (First, Middle,L WILLIAM NELSO)   | OLEMAN   |                               |                                 |  |   | 2. Date of Deat<br>Month<br>April 13, 2 | h<br>Dav Year                          | 3. Time of Death<br>0930 hrs  |
|   |                | 4a. Facility Name (if not institution, of 10803 Worton Road   |  |                               |                                 | Worton   | r Location of Deal                      |   | 4c. County of<br>Kent                  |   |
| Funeral<br>Director   |                | 215–58–5953   | Sex 7. A   | ge (In yrs. la<br>57          |                                 | Months Da  |   | _                                       | 1952<br>                               | Birthplace (State or Foreign Country) Maryland                                |
| Lyland sa-f show any tronce.  | Director       | Usual Residence of Decedent  10a, State  10b. County  MD  Kent  10e, Street and Number                |  |                               | Town or Loca<br>rton            | tion   |   | 110                                     | og. Citizen of Wha                     | 10d. Inside City Limits 1 XYes 2 No at Country?                               |
| rith the Mars or 28 or 28 or 28 or 28   | _ 1            | 10803 Worton Rd.  | 12. Was Deceder  | nt Ever in II 9               | 13 W/s                          | 21678  | spanic Origin? ( S                      | Specify Yes or No.                      | U.S.A.                                 | American Indian, Black,   |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  | by Funera      | 1 Never Married 2 Married 3 Widowed 4 X Divorce   | Armed Forces  1 Yes 2  ed If Yes, Give Year or Dates:                  | f Yes, Give Year<br>or Dates: |                                 | Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 X No specify:  nt's Usual Occupation (Give kind of work done |   |   | White, Specify:                        | white   |
| 1036<br>Aithin 72 hour<br>er than "natu<br>Medic 1 Ex.m   | Completed      | 15. Decedent's Education (Specify Elementary/Secondary (0-12)   | College (1-4 or 2  |                               | during m                        | ting Gui   | e. DO NOT use re<br>Lde                 | tired)                                  |  | -employed   |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than  | æ              | 17. Father's Name (First, Middle, La<br>William Nelson  | Coleman, S   | Sr.                           |                                 |  | Cather                                  | ne (First, Middle, M<br>rine Fore       | eman                                   |   |
| MD 2:<br>nd 2 should<br>alth and M<br>m 27 is m   | ٩              | 19a. Informant's Name/Relationship Kelly Smith 20a. Method of Disposition                             | (Type, Print)<br>(daughte  |                               | 2571                            | g Address (Stre  6 Meadow  sition (Name of ce  | Rd. Wo                                  | orton, MI  Date                         | 21678                                  | , State, Zip Code) City or Town, State  |
| Baltimore,<br>permit. Pages I al<br>Department of He<br>Important: If ite   |                | 1 Burial 2 X Cremation 3 4 Denation 5 Other Spec  | fy:  | tate cr                       | rematory or of<br>t Crem        | her place)<br>ation Se   | ervices                                 | 4/15/10                                 | Smyrna                                 | , DE.   |
|   |                | 21. Signature of Furferal Service Loc   |  | M00510                        | 111                             | 8 West (   | ross St.                                | . Galena.                               | ephen L.<br>MD. 210                    | 0.35  |
| Physician<br>/Medical<br>Examiner   |                | failure. List only one cause on   | each line. Cardion  Due to (or as a cons                               | egaly                         |                                 | ne mode or dying   | g, such as cardiac                      | or respiratory arre                     | st, shock, or near                     | Approximate Interval Between Onset and Death                                  |
| and the second  | ē              | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a cons  |                               |                                 |  |   |   |  |   |
| executed an and and and   | Examiner       | cause. Enter Underlying Cause<br>(Discass or injury that initiated<br>events resulting in death) Last | c. Due to (or as a cons  | sequence of)                  | ):                              |  |   |   |  |   |
| 50,<br>te be exec<br>nysician ar  | fedical        | X UNPENDED  | AMENDED 27   |                               |                                 | 3 5/6/10   | TT                                      |   | 23d. Date of c                         | delivery  |
| Box 68760, e death certificate be the attending physici ed for use as the buri  | Physician/Med  | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown                               | 1 Live birth 4 Pregnant a  | it time of dea                | 2 Fe                            | etal death 3<br>ther (Specify)   | Ectopic pregr                           | nancy                                   | Month                                  | Day Year  |
| P.O. res that the signed by be detached   | ð              | Part II. Other significant condition  | s contributing to dea  | th but not re                 | sulting in the I                | underlying cause   | given in Part I.                        |   |  | eute to the cause of death?  Probably 4  Unknown                              |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transit | Completed      | 25. Was case referred to medical  |  |                               | -                               | 26 Place   | e of Death (Check                       | 24a. Was a autop perfor                 | sy pr<br>m <u>ed</u> ? de              | ere autopsy findings available for to completion of cause of earth?  Yes 2 No |
| of Vital Recting Physician: The After this certificate funeral director, page   | o Be           | examiner?  1 ✓ Yes 2 No   | Hospital: 1 Inpati   | ient 2 . I                    | ER/Outpatient                   |  |   | , ,                                     | Residence 6                            | Other: Scene  |
|   | ation: T       | 27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigs                                       |  | jury<br>Year)                 | 28b. Time of                    |  | ury at Work?<br>Yes 2 No                | 28d. Describe h                         | now injury occurre                     | d   |
| Divisior To the Hospital or Attend within 24 hours after death To the Foneral Director: completely filled in by the   | Certification: | 3 Suicide 6 Could no determin   | ot be 28e. Place of I  | njury - At hor                | me, farm, stre                  | et, factory, office  | building, etc.                          | 28f. Location (S<br>or Town, S          |  | r or Rural Route Number, City   |
| To the Hoss<br>within 24 hd<br>To the Fun<br>completely   | Medical (      | 29a. Certifier 1 Certifying Physone) 2 Medical Examin   | ician: To the best of r<br>er:On the basis of exa<br>and manner stated | amination an                  | e, death occu<br>d/or investiga | rred at the time, o<br>tion, in my opinio  | date and place, an<br>n, death occurred | d due to the caus<br>at the time, date  | e(s) and manner a<br>and place, and du | as stated.<br>e to the cause(s)   |
| • F \$ F 3  | Me             | 29b. Signature and title of certifier   | m  |                               |                                 | 29c. Licen<br>O.C  | se number<br>.M.E.                      |   | 29d. Date signer<br>April 14, 20       | d (Month, Day,Year)<br>10   |
|   |                | 30. Name and address of person who Donna M. Vincenti, MD  | Assistant Medi   | cal Exam                      | iner 11                         | Penn Stree   | t, Baltimore, M                         | MD 21201                                |  |   |
| St<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year) APR 2 3 2010  | Serena 32. Registr   | ar's Signatu                  | arkel                           |  |   |   |  |   |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |   | For State of Marylar  1 - State Registrar  | -                 | ertment of Heartificate of De                                    |                         |                                      | ene<br>. No. 2 A   A           | 12701.                              |  |
|---------------------|---|---|--|-------------------|--|-------------------------|--------------------------------------|--------------------------------|-------------------------------------|--|
|                     |   |   | Decedent's Name (First, Middle, Last)  | 2. Date of Death  |  | 3. Time of Death        |                                      |                                |                                     |  |
|                     | Physici   |   | James Thomas Dennison  |                   |  |                         | Month                                | Day Year 1.1 2010              | 1:35 A M                            |  |
| and the             | /Medic<br>Examin  |   | 4a. Facility Name (If not institution, give street and number)   |                   | 4b. City, Town, or Lo  | cation of Death         | April                                | 4c. County of Death            | 2133 12                             |  |
|                     | LAGIIIII  | CI  | 1676 Langley Dr. Apt 303   |                   | Hagerston  |                         |                                      | Washingto                      | n County                            |  |
|                     | Funeral   |   | 5. Social Security Number 6. Sex 7. Age (In yrs.   | last birthday)    | If Under 1 Year If   | Under 24 Hrs.           | 8. Date of Birth                     | 9 Birth                        | place (State or Foreign             |  |
|                     | Director  | $\begin{array}{c ccccccccccccccccccccccccccccccccccc$ |  |                   |  |                         |                                      | ,1944 Penn                     | sylvania                            |  |
|                     | pu  |   | Usual Residence of Decedent  10a. State 10b. County 10c. Ci  | ty, Town or Lo    | nation   |                         |                                      | 1.                             | 0d. Inside City Limits              |  |
|                     | sho   | ō   |  | gersto            |  |                         |                                      |                                | 1 ∐Yes 2X No                        |  |
|                     | 28a-1   | Director  | 10e, Street and Number   |                   | 10f. Zip Code  |                         | 100                                  | . Citizen of What Cou          |                                     |  |
|                     | with with   | ē   |  |                   | 21740  |                         |                                      |                                | iti y :                             |  |
|                     | ns 23   | Funeral   | 1676 Langley Dr. Apt 303  11. Marital Status 12. Was Decedent Ever in U  | S. 13.V           |  | anic Origin? (Spe       |                                      | U.S.A.                         | can Indian.                         |  |
| (0                  | rter d  | Fu  | Armed Forces?  1 Never Married 2 Married 1 Yes 2 No  |                   | Was Decedent of Hispa<br>f Yes, specify Cuban, I                 | Mexican, Puerto         | Rican, etc.)                         | Black, White,                  |                                     |  |
| e<br>e              | be lied within /2 hours after death with the Maryland tall Hygiene. And other than "natural", or items 23a or 28a-f show event, the "Medical Econological to profitted at | þ   | 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  | 1                 | I∐Yes 2∏XNo 3  | Specify:                |                                      | Specify: Wh                    | ite                                 |  |
| 2-0                 | 72 ho   | Completed   | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Deced        | dent's Usual Occupation  | on<br>ina most of worki | 16                                   | b. Kind of Business/In         | dustry                              |  |
| 2                   | an Je   | du  | Elementary/Secondary (0-12) College (1-4or 5+)   | life. L           | DO NOT use retired)  | ing most or work        |                                      | 1.7                            |                                     |  |
| 2                   | Hygier<br>Hygier<br>ther th   | So  | 11   | Labor             |  |                         |                                      | luminum Mf                     | g. Co.                              |  |
|                     | 0 9   | Be  | 17. Father's Name (First, Middle, Last)  |                   |  |                         | (First, Middle, Ma                   | · ·                            |                                     |  |
| $\frac{8}{5}$       | should be t<br>and Mental<br>s marked o<br>numatic eve  | 2   | George H. Dennison   |                   |  |                         | Johnson D                            |                                |                                     |  |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.                                      |   | 19a. Informant's Name/Relationship (Type. Print)  LaDonna I. Dennison-wife   |                   | •  |                         |                                      | City or Town, State, Zi        | •                                   |  |
| a) .                | Tang<br>Healt<br>em 2<br>ther   |   |  |                   |  |                         |                                      | stown, MD                      |                                     |  |
| altimore,           | ages<br>nt of<br>r: If it   |   |  |                   | sition ( <i>Name of</i><br>natory or other place)<br>19 Cremato: | 1                       |                                      | ,                              |                                     |  |
|                     | artme<br>ortan<br>Injury  |   | 4 □ Donation 5 □ Other (Specify) SIII  21. Signature of Funeral Service Licensee   |                   |  |                         |                                      | mithsburg,<br>Fiery Fune       |                                     |  |
| Ba                  | Depril<br>Impo  |   | Monda A Fin  |                   |  |                         |                                      | gerstown.                      |                                     |  |
|                     |   |   | 23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.   | <del></del>       |  |                         |                                      | _                              | Approximate                         |  |
| ~ .                 | hysician  |   | Immediate Cause (Final   | 10                | . /  |                         |                                      |                                | Interval Between<br>Onset and Death |  |
|                     | /Medical  |   | disease or condition resulting in death)  a. Due to (or as a consecution of the control of the c | mence of).        | 1 lung   | cana                    | W                                    |                                | MONTH J                             |  |
| المحميد             | xaminer   |   | But 10 (01 do d 0011000  | querioc or).      | O  |                         |                                      | 1                              |                                     |  |
|                     |   | ner   | Sequentially list conditions, if any teaching to immediate course. Extra Underthings   | ran evol):        |  |                         |                                      |                                |                                     |  |
|                     | cured<br>nd<br>ransil   | Examiner  | day, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c   |                   |  |                         |                                      |                                |                                     |  |
| oʻ                  | e exe<br>ian al<br>ır <b>ial</b> -t   |   | resulting in death) Last Due to (or as a conseq  |                   |  |                         |                                      |                                |                                     |  |
| 09/89               | ueaur centilicate be executed<br>e attending physician and<br>d for use as the burial-transit   | edical  | d  |                   |  |                         |                                      |                                |                                     |  |
| 9                   | attending p   | Mec   | IF FEMALE:   |                   |  |                         |                                      |                                |                                     |  |
| POX                 | attend<br>or us   | ian/  | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  |                   |  |                         |                                      | 23d. Date of delive            | ery<br>Day Year                     |  |
|                     |   | Physician/M   | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of 9 ☐ Unknown   | death 5L          | Other (specify)  |                         |                                      |                                |                                     |  |
| J.                  | iaw lequiles first tils<br>as been signed by th<br>2 should be detache  |   | Part II. Other significant conditions contributing to death but not res  | sulting in the ur | nderlying cause given i  | in Part I.              | 23e. Did toba                        | cco use contribute to          | he cause of death?                  |  |
| Records,            | sign<br>sign<br>d be  | d by  |  | -                 |  |                         | 1 <b>∑</b> Yes                       | 2 No 3 Pro                     | bably 4 🗌 Unknown                   |  |
| ဂ္ဂ                 | been si<br>should t   | lete  |  |                   |  |                         | 24a. Was an                          | 24h Were aut                   | ppsy findings available             |  |
| r ;                 | <u>v</u> <u> </u>   | Completed   |  |                   |  |                         | autopsy<br>performe                  | prior to co                    | impletion of cause of               |  |
|                     |   | o<br>C  | 25. Was case referred to medical   |                   | 24   | 6 Dings of Doot         | 1 Tyes 2                             | No 1 □Yes                      | 2 □No                               |  |
|                     | 0 =   | <u>m</u>  | examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐   | ER/Outpatien      | Othor  |                         |                                      | ce 6 ☐ Other (Spec             | f <sub>V</sub> )                    |  |
| 0 4                 | h.<br>After thi<br>funeral o  | Ë   | 27. Manner of Death 28a. Date of Injury  | 28b. Time of      |  |                         | 28d. Describe how                    |                                | .97                                 |  |
| o i                 | ath.<br>ne fur  | atio  | 2 Accident investigation   | Injury            |  | s 2 □No                 |                                      |                                |                                     |  |
| DIVISION OF         | after death. I Director: After din by the funers  | Certification: To                                     | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Speci  | ome, farm, stre   | eet, factory, office   |                         | 28f. Location (Stre<br>City or Town, | et and Number or Rur<br>State) | al Route Number,                    |  |
| 5 }                 | rs aft<br>rs aft<br>rs aft<br>led in  | Cer   |  |                   |  |                         |                                      |                                |                                     |  |
|                     | 4 hou   | edical  | 29a. Certifier (Check only)  1 Certifying Physician: To the best of my knd 2 Medical Examiner: On the basis of examina   |                   |  |                         |                                      |                                |                                     |  |
| 4                   | within 24 hours after  To the Funeral Direct  completely filled in by   | Medi  | one) and manner stated.  |                   |  |                         |                                      |                                |                                     |  |
| , F                 | 2 ∰ <b>2</b> ⊗  | -   | 29b. Signature and title of certifier  |                   | 29c. License n   |                         |                                      | d. Date signed (Month,         |                                     |  |
|                     |   |   | my ms  |                   | 17458  | 15                      | <i>P</i> <sub>1</sub>                | PRIL 14,                       | LDIU                                |  |
| 21                  | 1.5+1   |   | 30. Name and address of person who completed cause of death (Iter  | m 23a) (Type,     | Com a · V  | 11.                     | 120 0000                             | mp 217                         | 42                                  |  |
|                     | Sta   | te.   |  | ature             | CHMPHJ K   | حامله                   | enst ma                              | THE LIT                        |                                     |  |
|                     | Registr   |   | APR 14 2010  | 1. 1              | all  |                         |                                      |                                |                                     |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 ear APRIL 5:40 A DAYS CORA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S CAROL MANOR NURSING HOME ADELPHIA If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. JAN 14 1926 VIRGINIA 84 153-26-8953 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 1 XYes 2 No HYATTSVILLE PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 USA 9272 ADELPHI ROAD # 104 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 ☐ XNo Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12TH DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ADDIE JOHNSON FLOYD WILEY SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9272 ADELPHI ROAD # 104 HYATTSVILLE, MARYLAND 20783 GAILA M. DUNN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 4/14/2010 RIVERDALE, MARYLAND J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Sign II - Funeral Serv to Hit ensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final FAILURE TO THRIVE disease or condition resulting in death) Due to (or as a consequence of): DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of): Cause (Disease or linjury

Physician/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran

signed by the attending p I be detached for use as ed by

page 2 s

after death. filled in by the

24 hours a Funeral I

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Physician/

Medical

Examiner

**Funeral** 

Director

show

28a-f

rms 23a or

Examiner

the Medical

items

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"natural",

h and Mental Hygiene.
7 is marked other than "r

permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic eve

notified at

Director

Funeral

Completed by

Be

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by Be Certificate: To

| resulting in death) Last  | Due to (or as a consequence of):  |   |  |  |
|---|---|---|--|--|
|   | d   |   |  |  |
| FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23d. Date of delivery  Month Day Year   |   |  |  |
| art II. Other significant conditions co   | ontributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death?  |  |  |
| OSTEPROSIS  | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown   |   |  |  |
|   |   | 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 124b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No |  |  |
| 5. Was case referred to medical   | 26. Place of Death (Che   | ck only one)  |  |  |
| examiner?<br>1  Yes 2  No   | Hospital:  1  Inpatient 2  ER/Outpatient 3  DOA Other: 4 Nursing F  | ome 5 Residence 6 Other (Specify)   |  |  |
| 7. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation              | 28a. Date of injury (Month, Day, Year)  28b. Time of injury injury  28c. Injury at work?  1 \[ \subseteq \text{ Yes}  2 \] No | 28d. Describe how injury occurred   |  |  |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)   |  |  |

1 칦 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) APRIL 6, 2010

To the Hosp within 24 ho To the Fune completed fi State

Division of Vital Records, P.O. Box 68760

BUSTOS M.D. 31. Date filed (Month, Day, Year) APR 0 9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10810 DARNESTOWN ROAD # 202 GAITHERSBURG, MARYLAND 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April GLADYS J. DIBBLE 2010 6,  $P^{M}$ 4:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) une 8,1928 Months Days Hours Min. 059-22-4044 1 □ M 2 👿 F New York 81 June **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 458 Girard Street 20877 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 **X** No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: If Yes, Give Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Engineering Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Patton Bessie Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen I. Fritz 19500 Pine Cone Court Gaithersburg, MD 20879 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Painters VIIIe and Missionary Alliance 1 X Burial 2 Cremation 3 Removal from State April 12, Lewistown, PA 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, 20877 MD23a. Part 1. Enter the disease, or complications to at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pneumonia Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-t Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month 5 Other (specify) Day Pregnant at time of death 1 Yes 2 a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an cate has page 2 s autopsy performed? certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\overleftarrow{\mathbf{X}}$  Other (Specify)  $\overleftarrow{\mathbf{Hospice}}$ Hospital: မှ 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After X Natural
Acciden
Suicide work? injury 5 Pending 2 No Accident Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records,

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31. Date filed (Month, Day, Year) State APR 09 2010 Registrar

(Check

29b. Signature and title of certifier



dele

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D55258

29d. Date signed (Month, Day, Year)

April 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>2010 Physician/ April 8, 6:00 ам Linda Dianne Ford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 5140 Port Tobacco Road Nanjemoy 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) Sept. 14, 1947 1 M 2 XF 220-48-9090 Maryland 62 Director Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Charles Nanjemoy Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5140 Port Tobacco Road 20662 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. \$ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Buyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of Ruth Elizabeth Hurd James Thorton Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health ar Important: If item 27 is 5140 Port Tobacco Rd., Nanjemoy, Md. 20662 Husband Edwin Baker Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) April 9, Date 2010 20a. Method of Disposition 20c. Location - City or Town, State any injury or 1 

Burial 2 

Cremation 3 

Removal from State Metropolitan Funeral Service Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, 20640 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final encer cert Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Inknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 မ ER/Outpatient 3 DOA 1 Inpatient 2 I within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) BRW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 0 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#1.PerPhys.PGC4-13-10cCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nannie Jane Fralin Physician/ Month 03 2010 Nanny Jane Fralin 9:40am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 302 Bathurst Street <u>Upper Marlboro</u> Georges 8. Date of Birth (Month, Day, Year) 07/22/1935 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 💢 F Hours Min. Director 233-54-9922 74 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince Georges Upper Marlboro 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 302 Bathurst Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes if Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced al Hygiene. d other than "natura event, the Medical E Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Manager HUD-FederalGovernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Ward Pauline Doyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Marlboro, MD 20774 302 Bathurst St. Franklin D. Fralin/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Department of Important: If any injury or Ft. Lincoln Cemetery 4/2/2010 4 Donation 5 Other (Specify) Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home Montgome 3401 Bladensburg Rd. Brentwood, MD 20722 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death supranulow Priysician/ Progressive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury burial-transi hyperlipidemia and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death signed by the s d be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 V Unknown Completed funeral director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ည 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4.8.10 COVERING

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2010

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                     |  |                    | For State Registrar   | State of Mary   |                                    | rtificate of   |   | , ,  | Jierie<br><sub>leg. No</sub> 2 ()   ()   | 12709  |  |
|---------------------|--|--------------------|---|---|------------------------------------|--|---|--|--|--|--|
|                     | Physici  |                    |   |   |                                    |  |   |  | th Day 2010  | 3. Time of Death<br>9:30 Рм                        |  |
| many .              | /Medic<br>Examin   |                    | 4a. Facility Name (If not institution, give   |   | me                                 | 4b. City, Town, o                                      |   | April April                                    | 4c. County of Dea  |  |  |
|                     | Funeral<br>Director  |                    | 5. Social Security Number 6. Social Security Number 1220–18–0022  | yrs. last birthday)<br>86 Yrs.  | If Under 1 Year<br>Months Days     | If Under 24 Hi<br>Hours Mir                            | 9. Birthplace (State or Foreign<br>Country)<br>1923 West Virginia |  |  |  |  |
| 98                  | yland<br>now   |                    | Usual Residence of Decedent  10a. State 10b. County   | 100   | . City, Town or Lo                 | cation   |   |  |  | 10d. Inside City Limits                            |  |
|                     | e Mary<br>8a-f sh  | ctor               | Maryland Frederic   | ck F  | rederick                           |  |   |  |  | 1 XYes 2 No  |  |
|                     | with th  | Dire               | 10e. Street and Number 430 Carrollton Dra   | ive   |                                    | 10f. Zip Code 2170                                     | 01  | 1  | 10g. Citizen of What C   |  |  |
|                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It. Modical Examination must be reallined at once. | y Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married   | 12. Was Decedent Ever in Armed Forces? 1                                | 1                                  | Was Decedent of H<br>fYes, specify Cuba<br>1 □Yes 2 No | lispanic Origin?<br>an, Mexican, Pue<br>Specify:                  | (Specify Yes or No-<br>erto Rican, etc.)       | 0  |  |  |
| 21215-0036          | 2 hour<br>natural'<br>ice Ex   | Completed by       | 3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed (Specify only highest gra-  | Year or Dates:  | 16a. Deced                         | dent's Usual Occup                                     | ation   | a wisin a                                      | 16b. Kind of Business  |  |  |
| 121                 | within 7<br>ene.<br>than "n  | mple               | Elementary/Secondary (0-12)   | College (1-4or 5+)  | 1                                  | kind of work done<br>DO NOT use retired<br>od Proces   |   |  | Canning Fa   | ectory   |  |
| ام<br>2             | e filed vall Hygie<br>other i  | Be Co              | 17. Father's Name (First, Middle, Last)   |   | FO                                 | od 110ces  |   | ame (First, Middle, I                          |  | ictory   |  |
| ylar                | iould be<br>di Mental<br>narked o  | 70<br>E            | Thomas Frank Sease  |   |                                    |  |   | le Davis                                       |  |  |  |
| Mai                 | and 2 sh<br>ealth and<br>n 27 is n   |                    | 19a. Informant's Name/Relationship (7 Dennis W. Ford / 8  | ,   |                                    |  |   |  | r, City or Town, State,<br>D, Las Ve   | zip Code)<br>egas NV 89115                         |  |
| Baltimore, Maryland | Pages 1 a<br>nent of He<br>ant: If item<br>ury or othe   |                    | 20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify   | nemoval nom State i   |                                    | sition (Name of<br>natory or other place<br>t Cemete:  |   |  | 20c. Location - City o   |  |  |
| Balt                | permit. Departi Importi any inji   |                    | 21. Signatur of Juneral Arvice Cen  | see   | RÖ<br>12                           | Name and Addre<br>BERT E. I<br>01 NORTH                | SATLEY &<br>MARKET  | SON FUNE<br>STREET, F                          | RAL HOMES,   | P.A.<br>MD 21701                                   |  |
|                     | Physician<br>/Medical<br>Examiner  | er                 | 23a. Part 1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>immediate Cause (Final<br>disease or condition<br>resulting in death)  Sequentially list conditions<br>if any, leading to immediate | one cause on each line.   | sequence of):                      | er the mode of dyling CSTONA                           |   | ac or respiratory arr                          | isons:   | Approximate<br>Interval Between<br>Onset and Death |  |
| 68760,              | tificate be executed<br>g physician and<br>as the burial-transit   | ledical Examiner   | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c   | sequence of):                      |  |   |  |  |  |  |
| . Box               | death cer<br>e attendir<br>d for use   | Physician/Me       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pregnancy  1                                    |                                    |  |   |  | 23d. Date of d<br>Month  | elivery<br>Day Year                                |  |
| S, F                | ires that<br>signed t  | þ                  | Part II. Other significant conditions co  | entributing to death but not  | resulting in the ur                | nderlying cause giv                                    | en in Part I.   |  |  | to the cause of death?                             |  |
| al Records,         | sician: The law requires that the certificate has been signed by th rector, page 2 should be detache   | Completed          |   |   |                                    |  |   |  | 24a. Was an autopsy performed?  1 \[ \gamma \text{s} = 2\text{No} \]  1 \[ \gamma \text{s} = 2\text{No} \] |  |  |
| Z K                 | sician<br>s certifi<br>irector   | o Be               | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No  | Hospital:   | O T FD/Outration                   | Oth  |   | eath (Check only or                            |  |  |  |
| n of                | ng Phy<br>fter this<br>neral d   | P-16               | 27. Manner of Dath  | 28a. Date of Injury<br>(Month, Day, Yea                                 | 2 ER/Outpatien 28b. Time of Injury |  | y at /  |  | ence 6 Other (Sp<br>ow injury occurred   | ecity)   |  |
| Division of Vital   | Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, p   | Certification:     | 1   Matural   5   Pending   (Month, Day, Year)   Injury   Work?   |   |                                    |  |   | 28f. Location (S.<br>City or Town              | treet and Number or F<br>n, State)   | Rural Route Number,                                |  |
|                     | ne Hospitt<br>n 24 hours<br>ne Funera<br>pletely fille   | Medical C          | 29a. Certifier (Check only one)  1 Certifying Ph  | /sician: To the best of my iner: On the basis of examend manner stated. | knowledge, death                   | n occurred at the ti<br>vestigation, in my o           | me, date and pla  | ice, and due to the c<br>curred at the time, c | cause(s) and manner<br>date and place, and du  | as stated. ue to the cause(s)                      |  |
|                     | To the within 2 To the comple  | ž                  | 29b. Signature and title of certifier   |   |                                    | 29c. Licens  | e number<br>0 47 9  |  | 29d. Date signed (Mor  |  |  |
|                     |  | ŀ                  | 30 Name and address of person who d   | ompleted cause of death   | (Item 23a) (Type.                  |  | ·^  | 0  | 4-07-  | -010   |  |
|                     | 2  | 4                  | SIBTE A. KAZMI  | , MD 81   | 110T P                             | House  | AUE -   | TREDER!  | CK. My   | 21701.   |  |
|                     | Sta  | te                 | 31. Date filed (Month, Day, Year)   | 32. Registra's S  | ignature                           | had.   |   |  |  |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wiley Gaither Griffith Apri1 2010 1:39 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital 01nev Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) (Month, Day, Months Days Hours Min Maryland **Director** 217-36-7735 1914 95 June Usual Residence of Decedent 10a. State within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Md. Montgomery Gaithersburg 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6010 Olney-Laytonsville Road 20882 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes, Give 1 Yes 2 No Specify: White Specify: "natural", 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Warfield Griffith Cornelia Greenberry Gaither 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie A. Griffith / Wife 6010 Olney-Laytonsville Rd., Gaithersburg, Md. 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Goshen Cemetery 4/9/2010 Goshen, Maryland Signature of Funeral Service License 22. Name and Address of Facility
Muriel H. Barber Funeral Home 20882 Box 5038, Laytonsville, 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 1ents cula Medical Due to (or as a consequence of) Examiner hemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last UPote inding physician and use as the burial-trans Due to (of as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 2 X No 1 Yes 2 No Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: 1 Yes Certificate: To 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🚅 🇲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certifier 29d. Date signed (Month, Day, Year, 00068026 2010 MD

DHMH 17 Rev 7/2009

State

Registrar

20

18101 Prince Philip Dr., #315, Olney, Md.

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GREACIES

Padmaja Bandi, M.D.

31. Date filed (Month, Day, Year)

10-02647 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Beatris Silvia Guzman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 5, 2010 **Medical Examiner** Beatriz Silvia Guzman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director None 1 M 2 X F 43 12/07/1966 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Md Hyattsville Prince George lother than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-5 sho Director 10e. Street and Number 10f. Zip Code 9004 Adelphi Road 20783 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married 2 X No Yes 1|X| Yes 2□ No specify: Guatemala 4 Divorced If Yes, Give Year Š 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Babysitter 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarvelio Guzman Paiz Elfia Cordon Morales 19a. Informant's Name/Relationship (Type, Print) Boris Jose Lemus Guzman/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 04/13/10 General Cemetery Donation 5 Other Specify 21. Signature of Funeral Service Licensee 23a. Part I. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line. /Medical a. Hemopericardium Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Aortic Dissection Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED the attending physician ed for use as the burial -UNPENDED law requires that the death certificate be 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a, Was an autopsy performed? ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 Yes

Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Guatemala 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? Guatemala 14. Race - American Indian, Black, White, etc. specify: Hispanic 16b. Kind of Business/Industry Self Employed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9004 Adelphi Rd. Hyattsville, Md. 20783 20c. Location - City or Town, State Guatemala 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th. St. NE Wash. D.C. 20017 Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box,68760 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 1 🗸 Yes 2 No Other Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 1 Yes 2 No the Pending \_\_\_ Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) within 24 hours a To the Funeral I determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 6, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

0137 hrs

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   | •                | For<br>State<br>Registrar   |                                       | State of Ma   | aryland                |  | artment of H<br><i>tificate of D</i>                     |                                  |  | giene<br><sub>Reg. No.</sub> 2 | 010                            | 12712  |
|---------------------|---|------------------|---|---------------------------------------|---|------------------------|--|--|----------------------------------|--|--------------------------------|--------------------------------|--|
|                     | Physicia  |                  | 1. Decedent's Name<br>Charles E   | (First, Middle, Las<br>Prederick      | st)<br>Gieseking  |                        |  |  |                                  | 2. Date of De<br>Month<br>April 7,                               |                                | Year                           | 3. Time of Death                                   |
|                     | Medical Examiner  4a. Facility Name (if not institution, give street and number)  Montopmery General Hospital   |                  |   |                                       |   |                        | 4b. City, Town, or Location of Death Olney |  |                                  | 4c. County of Death  Mon topomery                                |                                |                                |  |
|                     | Funeral<br>Director   |                  | 5. Social Security Nu 558–26–841  | birthday)<br>Yrs.                     | If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) |                        |  | th<br>X, Year)<br>1924                                   | Birthplace (State or Foreign     |  |                                |                                |  |
| _                   |   | <u>-</u>         | Usual Residence of I<br>10a. State  | Decedent<br>10b. County               |   | 10c. City, T           | Town or Lo                                 | cation   |                                  |  |                                | 1                              | 10d. Inside City Limits                            |
|                     | Maryla<br>28a-f s<br>etified  | recto            | Maryland  |                                       | Montgomery  |                        | Olney                                      | 7  |                                  |  |                                |                                | 1 🗆 Yes 2 🌁 No                                     |
|                     | ith the<br>23a or 2<br>st be no   | Funeral Director | 10e. Street and Num   | ber<br>Carroll D                      | rive  |                        |  | 10f. Zip Code<br>20832                                   |                                  |  | 10g. Citizen<br>USA            | of What Cou                    | ntry?  |
| 9                   | 2 should be filed within 72 hours after death with the Manyland that and Mental Hygiene.  If hard Mental Hygiene.  If is marked other than "natural", or items 23a or 28a-f show 17 is marked other than "natural", or items 23a or 28a-f show 17 is marked other than "natural". | by Fune          | 11. Marital Status 1  Never Marrie  |                                       | 12. Was Decedent E<br>Armed Forces?<br>1 Yes 2  |                        |  | Was Decedent of His<br>f Yes, specify Cubar              | n, Mexican, Puerto               | ecify Yes or No-<br>Rican, etc.)                                 | 14. F                          | Race - Americ<br>Black, White, |  |
| Maryland 21215-0036 | ours af<br>atural",<br>cal Exa  | eted             | 3 Widowed 4   | Divorced  15. Decedent's E            | If Yes, Give<br>Year or Dates.  | WWII                   |  | l ☐ Yes 2 ☐ No<br>lent's Usual Occupa                    |                                  |  | Spec                           | of Business In                 | hite   |
| 215                 | nin 72 h<br>Je.<br><b>than "n</b> a<br><b>e Medi</b>  | Completed        | (Speci  | cify only highest gr                  | ade completed)  College (1-4 or 5   | +)                     | (Give I<br>life. D                         | kind of work done d<br>O NOT use retired)                | uring most of work               | ing  |                                |                                | 1  |
| d<br>2              | led with<br>Hygier<br>other t   | BeC              | 17. Father's Name (F  | irst, Middle, Last)                   | 5+  |                        | Psy  | rchologist   | 18. Mother's Nam                 | e (First, Middle,  |                                | al Gove:                       | rnment   |
| ylan                | ild be fi<br>Mental<br>narked<br>latic ev   | 욘                | Roy Giesek  |                                       |   |                        |  |  | Agnes                            | Unknown  |                                |                                |  |
| , Mar               | ge 1 and 2 should be<br>it of Health and Men<br>I if item 27 is marke<br>or other traumatic   |                  |   | . Giesekin                            |   |                        | 3501                                       | John Carrol  | nd Number or Rura<br>Ll Drive, O | al Route Number, City or Town, State, Zip Code)  1 ney, MD 20832 |                                |                                | Code)  |
| Baltimore,          | Pag<br>ant<br>ury   |                  |   |                                       | Removal from State  | cem                    | netery, cren                               | sition (Name of<br>natory or other place<br>on Crematory | Apri<br>20                       | I <sup>ate</sup> 9,  |                                | on - City or To                | own, State<br>Virginia                             |
| Balt                | permit, Departr Imports any inji  | l "              | 21. Signature of Fun  | eral Service Licen                    | the Mat   | /                      | 22   | Name and Address<br>000 Universi                         | olffins Fun<br>Lty Blvd. W       | eral Home<br>., Silver   | Inc.<br>Spring                 | , MD 20                        | 901  |
| -                   |   |                  | 23a. Part 1. Enter th<br>shock, or heart<br>Immediate Cause (F  | failure. List only o                  | plications that caused<br>one cause on each line  | he death. [            | Do not ente                                | 0 0  |                                  |  |                                |                                | Approximate<br>Interval Between<br>Onset and Death |
|                     | Medical   |                  | disease or condition resulting in death)  |                                       | a. + COO to (or as a  | a consequen            | rce of):                                   | ir gai   | Stage                            | 4  |                                | +                              |  |
|                     | Examiner  | ē                | Sequentially list conif any, leading to imi   | nuitions,                             | t. Prost  | CONSEQUEN              | CO   | meer.  | stage                            | 10   |                                |                                |  |
| B                   | uted<br>nd<br>ransit  | Examiner         | Cause (Disease or iinjury that initiated events   |                                       |   |                        |  |  |                                  |  |                                |                                |  |
| 0                   | icate be executed<br>g physician and<br>s the burial-transit  | edical E)        | resulting in death) Last  Due to (or as a consequence of):  |                                       |   |                        |  |  |                                  |  |                                |                                |  |
| 68760               | rtificate<br>ing phy<br>e as the  |                  | IF FEMALE:  |                                       | 00-16   |                        |  |  |                                  |  |                                | ĺ                              |  |
| P.O. Box (          | requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi  | Physician/M      | 23b. Was decedent printhe past 12 m<br>1 Yes 2 2<br>9 Unknown   | nonths?                               | 23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown                                | 2 🗌 Fetal d            | eath 3 L                                   | Ectopic pregnancy Other (specify)                        | /                                |  | - 1                            | Date of deliv<br>Month         | ery<br>Day Year                                    |
| s, P.O              | r requires that the de<br>been signed by the<br>should be detached  | þ                | Part II. Other signific   | cant conditions o                     | ontributing to death b  | ut not resulti         | ing in the u                               | nderlying cause give                                     | en in Part I.                    | 23e. Did to  | 1                              |                                | he cause of death?                                 |
| Records,            | ne law requite has beer<br>age 2 shou   | Completed        |   |                                       |   |                        | -  |  |                                  |  | osy<br>ormed?                  | prior to co<br>death?          | psy findings available impletion of cause of       |
| ta H                | sician: The la<br>certificate ha<br>irector, page 2   | Be               | 25. Was case referre  |                                       | Hospital:   |                        |  |  | ce of Death (Checi               | 1 L Yes  | 2 14 146                       | 1 Yes                          | 2 LJ NO  |
| ا ح                 | y Physi<br>er this c<br>eral dire   | e: 10            | 1 ☐ Yes 2 ☐<br>27. Manner of Death  | PNO                                   | 1 1 Inpatie   | y 28                   | b. Time of                                 | ot 3 DOA Othe  | 4 ☐ Nursing Ho                   | ome 5 Residence 128d. Describe h                                 |                                |                                | /)   |
| ion                 | tending<br>leath.<br>:or: Afte<br>the fun   | Certificate:     | 1 Natural 2 Accident 3 Suicide  | 5 Pending Investigation 6 Could not b |   |                        | injury                                     |  | Yes 2 No                         |  |                                |                                |  |
| Division of Vital   | al or At<br>s after o<br>il Direct<br>ed in by  |                  | 4  Homicide   | determined                            | 28e. Place of Inju<br>building, etc   |                        | e, farm, stre                              | eet, factory, office                                     |                                  | 28f. Location (S<br>City or Tow                                  |                                | mber or Rura                   | l Route Number,                                    |
|                     | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s   | Medical          | (Check 2  | Medical Exam                          | sician: To the best of iner: On the basis of exserving the Bractioner: To the Bractioner:   | camination ar          | nd/or invest                               | igation, in my opinior                                   | n, death occurred at             | t the time, date a   | ind place, and                 | due to the ca                  | use(s) and manner stated.                          |
|                     | 10+1  |                  | 29b. Signature and title of pertifier  Plum HOSpitalist Doctors number  29c. License number  29d. Date signed (Month), Day, Year)  29d. Date signed (Month), Day, Year) |                                       |   |                        |  |  |                                  |  |                                | Day, Year)                     |  |
|                     | ( -   |                  | 30. Name and address  | s of person who                       | completed cause of de   | eath (Item 23<br>18101 | Ba) (Type, P                               | rint)<br>Philip Dri                                      | ive, Olney,                      | MD 20832   | 2                              |                                |  |
|                     | Stat<br>Registra  |                  | 31. Date filed (Month   | Day, Year)<br>0 9 201                 | 2. Registra   | r's Signature          | bar  | 40   |                                  |  |                                |                                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> C. Physician/ Gaskins Month Mary 2:55pm April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Silver Spring Holy Cross Hospital Social Security Number 578-68-3645 7 Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Year)

May 4, 1950 Days 1 🗆 M 2 🔀 F Months 59 Yrs. Washington DC Director Usual Residence of Decedent ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Kensington M D 1 Yes 2 No 10f. Zip Code 20895 10e. Street and Numbe 10g. Citizen of What Country? Funeral 3000 McComas Avenue United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Š 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 Married Native Specify: American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d 2 should be filed within 72 atth and Mental Hygiene. Food Service Elementary/Seconday (0-12) Deli Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname)

Caroline Randall မ Adolphus Gaskins 19a. Informant's Name/Relationship (Type, Print)

Roy Gamble son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi 1346 Magnolia Avenue, Annapolis, MD 21403 Roy r nit. Page 1 and 2 sl prartment of Health a portant: If item 27 is y injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/09/2010 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundal Service Light 22. Name and Address of Facility McGuire Funeral Service, Inc. Der dany 7400 Georgia Avenue, NW, Washington DC 20012 ladre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Respiratory Distress Syndrome Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneu m onia Sequentially list conditions. Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). Urinary Tract Infection attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Multiple Sclerosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed Decubitus Ulcer, Hypertension, Obesity, DM 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2XXNc Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔼 No Other: 1 Tyes 1XXInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physisithin 24 hours after death.
 To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0068681 ss of person who completed cause of death (Item 23a) (Type, Print)

Maheshwary, MD 1500 Forest Glen Road, Silver Spring, Maryland 20910

DHMH 17 Rev 7/2009

State

Registrar

Maheshwary,

09 2010

31. Date filed (Month, Day, Year)

Box 68760

P.0.

Division of Vital Records,

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

10 East Deer Park Drive Gaithersburg, MD. 20877 Approximate
Interval Between
Onset and Death

Weeke 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. physician and s the burial-trans Physician/Medical led by the attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Ostevarthritis 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No М To the Hospital or Attend within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) N. Refert Birschbach MO. 04115 April 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL AVE BIRSCHBACH, M.B. GAITHERS & LRG, MD 20877 y, Year) 09 32 Registrar's Signature State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

4c. County of Death

Montgomery

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

Illinois

14. Race - American Indian,

White

Black, White, etc.

Specify:

Education

9:00 P M

2. Date of Death

1271

|                  |  |                | 1 = For<br>State<br>Registrar   | State of Marylar  |                                  | artment of F<br>rtificate of I                |   | , ,   | ene<br>1. No.                               |  |  |
|------------------|--|----------------|---|---|----------------------------------|---|---|---|---|--|--|
| Physician        |  |                | 1. Decedent's Name (First, Middle, Last,<br>Helen   | Elizabeth   | Hinkle                           |   |   | 2. Date of Death<br>Month Day Year          |   | 3. Time of Death                               |  |
| /Medic<br>Examin |  |                |   |   |                                  | 4b. City, Town, or Location of Death          |   | -   | 2, 2010<br>4c. County of Death              | L 6:15 A ™                                     |  |
| ,                | Examili  | er             | Devlin Manor He   | ŕ   | nter                             |   | nberland                                    |   | Allegany                                    |  |  |
|                  | Funeral  |                | Social Security Number 6. Sec.  | 7. Age (In yrs.   |                                  | If Under 1 Year                               | If Under 24 Hrs.                            | 8. Date of Birth                            | 9. Birth                                    | place (State or Foreign                        |  |
|                  | Director   |                | 210-14-14/2   | M 2₹F 88  | Yrs.                             | Months Days                                   | Hours Min.                                  | (Month, Day, Y                              |   | land   |  |
|                  | nd.  |                | Usual Residence of Decedent  10a. State 10b. County   | 100 0   | to Taum and a                    |   |   |   |   |  |  |
|                  | sho  | ō              |   |   | ty, Town or Lo                   |   |   |   | '   | 0d. Inside City Limits 1 ☐ Yes 2 ☒ No          |  |
|                  | the N  | Director       | MD Allega  10e. Street and Number   | TIY   | Cu                               | mberland                                      |   | 10-   | Cisinan of Wilest Cour                      |  |  |
|                  | with   |                | 10610 Hinkle Ro   | ad. NE  |                                  | Toi. Zip Code                                 | 21502                                       | 100   | g. Citizen of What Cour<br>USA              |  |  |
|                  | ms 2   | Funeral        |   | 12. Was Decedent Ever in U  | .S. 13. \                        | Nas Decedent of H                             | ispanic Origin? (Sp<br>an, Mexican, Puerto  | ecify Yes or No-                            | 14. Race - Americ                           |  |  |
| 21215-0036       | iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other fraumatic event, the Medical Examinar must be notified at | þ              | 1 ☐ Never Married 2 ☐ Married<br>3 🖾 Widowed 4 ☐ Divorced   | Armed Forces? 1   |                                  | fYes, specify Cuba<br>I⊡Yes 2∏XNo             | an, Mexican, Puerto<br>Specity:             | Rican, etc.)                                | Black, White,                               |  |  |
| 2-0              | 72 ho  | Completed      | 15. Decedent's Edu<br>(Specify only highest grad  | cation  | 16a. Deced                       | dent's Usual Occup                            | ation                                       | ing 16                                      | b. Kind of Business/In                      | dustry   |  |
| 21               | filed within 72<br>Hygiene.<br>other than "na<br>ent, the Medic  | mpk            | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                                  |   | during most of work<br>f)                   | ing   |   |  |  |
| 2                | led w<br>Hygie<br>her tl   |                |   |   |                                  | Homemake                                      |   | 450 - 140 - 14                              | Home  |  |  |
| anc              | d be fi  | Be             | 17. Father's Name <i>(First, Middle, Last)</i><br>Bruce   | Peter.  | Straw                            | ,   | 18. Mother's Name                           | e <i>(First, Middle, M</i> a<br>E1]         | · ·   | Montgomery                                     |  |
| Maryland         | 2 should<br>and Mer<br>is marke<br>aumatic   | 7              | 19a. Informant's Name/Relationship (Ty  | ne Print)   |                                  |   |   |   | City or Town, State, Zig                    | -  |  |
|                  | and 2 sealth ar  |                | William C. Straw,   | ,   |                                  | -   |   | ,   | ony or nown, state, 21,<br>Cland, MD        | 21502  |  |
| Ē,               | s 1 a  |                | 20a. Method of Disposition  | 20b. I  |                                  | sition (Name of<br>natory or other plac       |   |   | c. Location - City or To                    |  |  |
| E                | Pages<br>nent of<br>int: If Its<br>iry or o  |                | 1XXBurial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Domation 5 ☐ Other (Specify)   |   |                                  |   |   | /06/2010                                    | Cumberlar                                   | nd MD  |  |
| Baltimore,       | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.   |                | 21. Si mature di Funeral Service License  |   | 22                               | . Name and Addres                             | ss of Facility Ad                           | ams Famil<br>t, Cumber                      | y Funeral                                   | Home, P.A.<br>21502                            |  |
|                  |  |                | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or  | cations that caused the deat<br>e cause on each line.                           | h. Do not ente                   | er the mode of dyin                           | g, such as cardiac                          | or respiratory arrest                       | t,  | Approximate<br>Interval Between                |  |
|                  | Physician  |                | Immediate Cause (Final disease or condition   | Core  | -1                               | gell ble                                      | dde   |   |   | Onset and Death                                |  |
|                  | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a conseq  | uence of):                       |   |   |   |   |  |  |
|                  |  | ř.             | Sequentially list conditions,   | <br>Due to (or as a conseq  | Hence of):                       |   |   |   |   |  |  |
|                  | uted<br>3<br>Insit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter truellying Cause (Disease or injury that initiated events | Due to (or as a conseq  | deride oi).                      |   |   |   |   |  |  |
| ,                | exec<br>an and<br>ial-tra  | Еха            | resulting in death) Last  | Due to (or as a conseq  | uence of):                       | ·   |   |   |   |  |  |
| 6876U            | tificate be executed<br>g physician and<br>as the burial-transit   | edical         | d   |   |                                  |   |   |   |   |  |  |
|                  |  |                | IE EEMALE.  |   |                                  |   |   |   |   |  |  |
| X<br>R<br>R      | death cert<br>e attending<br>d for use a   | an/I           | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?  | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta                        |                                  | Ectopic pregnancy                             | /   |   | 23d. Date of delive                         | *  |  |
| 5                | the a  | Physician/M    | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4 ☐ Pregnant at time of o   | death 5                          | Other (specify)                               |   |   | Month                                       | Day Year                                       |  |
| 7.               | that the ed by detacl  |                | Part II. Other significant conditions con   | tributing to death but not res  | ulting in the un                 | iderlylna cause dive                          | on in Part I                                | 23e Did tohac                               | cco use contribute to the                   | ne cause of death?                             |  |
| ďŠ,              | sign<br>d be   | d by           |   | ren Derrorte  | _                                | acity mg caace give                           | on in rate i.                               |   | 2 ☐No 3 ☐ Prob                              |  |  |
| ecords           | v requ   | etec           | - Cargari   |   | -                                |   |   |   |   |  |  |
| Ď<br>Ľ           | he lav<br>e has<br>ge 2  | Completed      |   |   |                                  |   |   | 24a. Was an<br>autopsy<br>performe          | prior to co                                 | psy findings available<br>mpletion of cause of |  |
| NIT A            | an: T<br>tificat<br>or, pa   |                | 25. Was case referred to medical  |   |                                  |   | 00 51 (5 )                                  | 1 ☐ Yes 2 ☐                                 |   | 2 □No  |  |
| >                | yslcia<br>s cer<br>direct  | o Be           | examiner?   | ospital:<br>1  ☐ Inpatient 2  ☐   | EB/Outpatien                     | t 3 🗆 DOA Othe                                |   | n (Check only one)                          | e 6 ☐ Other (Specif                         |  |  |
| 0                | ig Ph  | n: To          | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day, Year)                                       | 28b. Time of                     | 28c. Injury<br>Work                           |   | 28d. Describe how                           |   | у)   |  |
| VISION           | ath.<br>Pr: Af   | atio           | 1   | (IVIOIIIII, Day, real)  | Injury                           |   | .r<br>Yes 2 □ No                            |   |   |  |  |
|                  | al or Atte<br>s after de<br>il Directo<br>ed in by ti  | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)           |   |                                  | eet, factory, office                          |   | 28f. Location (Stree<br>City or Town, S     | et and Number or Rura<br>State)             | l Route Number,                                |  |
|                  | To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached  | Medical        | 29a. Certifier (Check only one)  1  | ician: To the best of my knower: On the basis of examination and manner stated. | wledge, death<br>tion and/or inv | occurred at the ting<br>restigation, in my op | ne, date and place,<br>pinion, death occuri | and due to the cau<br>red at the time, date | se(s) and manner as seand place, and due to | stated.<br>o the cause(s)                      |  |
|                  | Vithi<br>Voti  | Σ              | 29b. Signature and title of certifier   |   |                                  | 29c. License                                  | number                                      | 29d   | 29d. Date signed (Month, Day, Year)         |  |  |
|                  | 3  |                | * Shell   | m mu  |                                  | 1000  | 17565                                       |   | Syr. 2, 2                                   | 010  |  |
|                  | h-a  |                | 30. Name and address of person who co   |   | n 23a) (Type, F                  | Print)  | L2U2  |   | 4   |  |  |
|                  | nds  |                | ATRILING MO   | 925 No.   | t 1                              | 1thy  | L2-U2                                       | ie MD                                       | 1/502                                       |  |  |
|                  | Stat   | е              | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signa   | ure Mad                          |   |   |   |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** HALL -IAM 3RD 2010 2:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center cumber and LIONS Allegany 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min 185-12-3748 1 M 2 □ F Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be inclined an BEDFORK Bedfore 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bedford Valley 15522 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ■Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 M No 3 NWidowed 4 □ Divorced White 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CARE OPTOMETRIST HEALTH 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be B Vesta Thompson Hall M. ည Clarence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cople) 2150 Z 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Ronald Leat 13202 Woodridge LN SW Comberland Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State Hindman F.H.'s cremat. 4-7-2010 Johnstown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harvey H. Zeigler FH INC 21. Signature of Funeral Service Licenses 169 Clarence St 15545 Hyndman 23a. Part 1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Unosepsis **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds 6a5 Avenue stque Kent umberland

State

Registrar

31. Date filed (Month, Day, APR 0 7

Year)

2010

32. Registrar's

**Physician** /Medical Examiner

permit. Page Department of Important; If any Injury or once.

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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23a, Parl 1

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Modical Expredict to set by notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit

Division of Vital Records, P.O. Box 68760,

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|----------------|---|--|---|---|---|
| Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown |  | pic pregnancy<br>r (specify)  |   | 23d. Date of delivery<br>Month Day Year                           |
| ğ              | Part II. Other significant conditions of Rheuma foid arth                               | contributing to death but not resulting in the underlyi  | ing cause given in Part I.  |   | use contribute to the cause of death?  2 No 3 Probably 4 Junknown |
| Completed      |   |  |   | 24a. Was an<br>autopsy<br>performed?<br>1 □ Yes 2 □ N |   |
| Be             | 25. Was case referred to medical  |  | 26. Place of Death  | (Check only one)                                      |   |
| 2              | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐  | DOA Other: 4 Nursing Ho   | me 5 🔀 Residence                                      | 6 ☐Other (Specify)  |
|                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation                  | 1  | 28c. Injury at Work? 1 □ Yes 2 □ No                                     | 28d. Describe how inju                                | ury occurred  |
| Certification: | 3 Suicide 6 Could not b<br>4 Homicide determined  |  | ctory, office   | 28f. Location (Street a<br>City or Town, Sta          | and Number or Rural Route Number,<br>te)                          |
| Medical        | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam                         | hysician: To the best of my knowledge, death occu<br>miner: On the basis of examination and/or investige<br>and manner stated. | rred at the time, date and place,<br>ation, in my opinion, death occurr | and due to the cause<br>ed at the time, date a        | (s) and manner as stated. nd place, and due to the cause(s)       |
| Ž              | 29b. Signature and title of certifier   | _  | 29c. License number   | 29d. D  | ate signed (Month, Day, Year)                                     |

D0059987

925 Seton Drive, Cumberland, MD

April 6, 2010

State

n RS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher Vagnoni, M.D.,

0 6 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2010 Physician/ April Edwin William Hayes, Jr. 07 8:00 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City Town, or Location of Death 4c. County of Death Asbury Solomons Health Care Center Solomons Calvert **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 1 M M 2 □ F Months Days Hours Min Director 579-36-1693 78 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be marked once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Calvert Solomons 1 ☐ Yes 2 1 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 501 Aldergate Court 20688 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer System Direction U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edwin William Hayes, Sr. Haru Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret F. Hayes / Wife 501 Aldergate Ct., Unit 501, Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 04/08/2010 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year the a g Unknown g | Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s performed No death? Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other ည 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner stated 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1 Jonathan Lowenthal, MD , 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra & Signature State 2010 Registrar

DHMH 17 Rev 7/2009

| 10-02465   | Ple                                  | ease Ty             | pe or Print i         | n Black Inde               | lible l  | nk. Ensure                                | All Co                       | pies Are l                               | _eaibl         | e. 2.0               | 110 271                          |
|--|--------------------------------------|---------------------|-----------------------|----------------------------|----------|---|------------------------------|--|----------------|----------------------|----------------------------------|
| Quamaine Shavazz   | Harris                               | St                  | ate of Maryl          | and / Departn              | nent o   | f Health and                              | d Menta                      | l Hygiene                                | 9              | Come to              | 2 1 1                            |
|  | 1- For State<br>Registrar            |                     |                       |                            |          | f Death                                   |                              | ,,,                                      | Reg. No        | ).                   |                                  |
| Physician/   | Decedent's Nam                       |                     | le,Last)              |                            |          |   |                              | 2. Date of I                             |                |                      | 3. Time of Death                 |
| Medical Examiner   | Quama                                | aine                |                       | Harris                     |          |   |                              | Month<br>March                           | Day<br>28, 201 | 0 Year               | 1938 hrs                         |
|  | 4a. Facility Name (                  | if not institution  | on, give street and n | umber)                     |          | 4b. City, Town, or                        | Location of D                | Death                                    | 4              | c. County o          | f Death                          |
|  |                                      | Prince Frederick Ca |                       |                            |          |   | Calvert                      |  |                |                      |                                  |
| Funeral  | 5. Social Security N                 | lumber              | 6. Sex                | 7. Age (In yrs. last bi    | rthday)  | If Under 1 Year                           | If Under 2                   | 4Hrs. 8. Date of                         | f Birth(MN     | 1/DD/YYYY)           | 9. Birthplace (State or          |
| Director   | 212-41-                              | -6803               | 1XM 2F                | 16                         | Yrs      | Months Days                               | Hours                        | Min. 12/                                 | 19/1           | 993                  | Foreign<br>Country) MD           |
|  | Usual Residence o                    | f Decedent          |                       |                            |          |   |                              |  |                |                      |                                  |
| any  | 10a. State                           | 10b. County         | •                     | 10c. City, Town            | or Locat | ion                                       |                              |  |                |                      | 10d. Inside City Limits          |
| land<br>F show   | MD                                   | Calv                | rert                  | Princ                      | ce F     | rederic                                   | k                            |  |                |                      | 1 Yes 2 X No                     |
| lary   | 10e. Street and Nu                   | mber                |                       | •                          |          | 10f. Zip Code                             |                              |  | 10g. Cit       | tizen of Wha         | at Country?                      |
| ith the Maryland 23s or 28s-f show notified at once. al Director                                       | 1752                                 | 0rwe1               | .1 Court              |                            |          | 2067                                      | 8                            |  | τ              | SA                   |                                  |
| r death with the Maryland<br>or items 23a or 28a-f shu<br>must be notified at once<br>Funeral Director | 11. Marital Status  1 X Never Marrie | ed 2 M              |                       | cedent Ever in U.S. orces? | 13. Wa   | as Decedent of Hisp<br>es, specify Cuban, | panic Origin?<br>Mexican, Po | ? ( Specify Yes or<br>uerto Rican, etc.) | No-            | 14. Race -<br>White, | -American Indian, Black,<br>etc. |

| alcai Exam  | iiriei                   | Quamaine narris  | March 28, 2010 1938 hrs  |
|---|--------------------------|--|--|
|   |                          | Sacility Name (if not institution, give street and number)     Calvert Memorial Hospital   | 4b. City, Town, or Location of Death Prince Frederick 4c. County of Death Calvert  |
| Funera<br>Director  |                          | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 212-41-6803 1X M 2 F 16   | yrs. If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or Foreign Country)   M.D.   12/19/1993   Country   M.D.   | id<br>how any   |                          | Usual Residence of Decedent  10a. State  | ocation 10d Inside City Limits Frederick 1 Yes 2 X No  |
| th the Maryland<br>23a or 28a-f show<br>notified at once.   | Director                 | 10e. Street and Number<br>1752 Orwell Court  | 10f. Zip Code 10g. Citizen of What Country? 20678 USA  |
| 7; MID & 1 & 10-10-30 and 2 should be filed within 72 hours after death with the Maryland (eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once | Funeral                  | 11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No  | Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.   |
| 2 hours after "natural", I Examiner   | <u>\$</u>                | 15. Decedent's Education (Specify only highest grade completed) 16a. Dece  | Yes 2 X No specify: Specify: Black  Ident's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired)   |
| L 1 L 13-UU30 uld be filed within 72 hou Mental Hygiene. marked other than "nat c event, the Medical Exa  | 1 5                      | 1 O  17. Father's Name (First, Middle, Last)   | Student High School  1B.Mother's Name (First, Middle, Maiden Surname)  |
| Defiuit Pages 1 and 2 ket 13-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Medi  | To Be                    | Lorraine Johnson  19a Informant's Name/Relationship (Type, Print)  Amy F. Harris/mother P.0  | Amy Felicia Harris  iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Box 74 Huntingtown, MD 20639   |
| ages 1 and 2 and 2 and 6 trick of Health 1t. If item 2 other traum  |                          | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  Ches H  | position (Name of cemetery, rother place) igh.Mem.Ga. 4/7/2010 Port Republic, MD   |
| Definition Pages 1 as Department of He Important: If ite injury or other tr   |                          |  | 2. Name and Address of Facility Sewell Funeral Home<br>451 Dares Beach Road Prince Fred., MD206  |
| hysician<br>/Medical<br>xaminer   |                          | a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries   | er the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval  Between Onset and  Death   |
| ed<br>nsit  | ysician/Medical Examiner | or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that hillistad events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |  |
| e be executed<br>sician and<br>burial - transi  | edical                   | d. UNPENDED AMENDED  |  |
| e death certificate be executed<br>the attending physician and<br>ed for use as the burial - transi   | /sician/M                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 9 Unknown   | Fetal death 3 Ectopic pregnancy Month Day Year  Other (Specify)  |
| requires that the de<br>been signed by the<br>hould be detached f   | by Pt                    | Part II. Other significant conditions contributing to death but not resulting in the   | e underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?  1  |
| To the Hospital or Attending Physician: The law requires that th within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach             | Completed                |  | 24a. Was an autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No   |
| ysician:<br>his certific<br>director, p   | Be                       | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient  | 26 Place of Death (Check only one)   |
| ttending Ph<br>leath.<br>tor: After t   | ation: To                | 27. Manner of Death 1 Natural 5 Pending Mai 28, 2010 1811 hrs 2 ✓ Accident Investigation   | of Injury 28c. Injury at Work?  1 Yes 2 No Operator of dirtbike struck fixed object  |
| To the Hospital or Attending Physician: The law requires that twithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detaa                | Certification:           | 3 Suicide 6 Could not be determined See. Place of Injury - At home, farm, si (Specify) Local Street  | or Town, State)<br>500 Block of Mason Road , Prince Frederick , MD   |
| To the He within 24. To the Fu completely   | edical                   | one) 2 Medical Examiner: On the basis of examination and/or investiged and manner stated.  | curred at the time, date and place, and due to the cause(s) and manner as stated. gation, in my opinion, death occurred at the time, date and place, and due to the cause(s)   |
|   | Ž                        | 29b. Signature and title of certifier  | 29c. License number 29d. Date signed (Month, Day, Year)  O.C.M.E.  OCME  March 29, 2010  |
| F   | 1                        | 30. Name end address of person who completed arise of death (florn 23a)  | D,I  |

| 1 ✓ Yes 2 No nospital. 1 Inpatient 2 ✓ ER/Outpatient   | 3 DOA Other Nursi                 | ng Home 5 Residence 6 Other:   |
|--|-----------------------------------|--|
| 27. Manner of Death  1 Natural 5 Rending Mar 28, 2014 (Page 1)  1 Natural 5 Rending Mar 28, 2014 (Page 1)  1811 hrs  |                                   | 28d. Describe how injury occurred  |
| Natural 5 Pending Mai 28, 2010 1811 hrs  | 1 Yes 2 ✓ No                      | Operator of dirtbike struck fixed object                                     |
| 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street  | t, factory, office building, etc. | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 4 Homicide determined (Specify) Local Street   |                                   | 500 Block of Mason Road , Prince Frederick , MD                              |
| 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2  Medical Examiner: On the basis of examination and/or investigat and manner stated. |                                   |  |
| 29b. Signature and title of certifier  | 29c. License number               | 29d. Date signed (Month, Day, Year)  |
| Thudow Mr. King JPu Min  | O.C.M.E.                          | March 29, 2010   |
| 30. Name end address of person who completed parse of death (Illum 23a)  |                                   |  |
| Theodore M. King, Jr., MD. Assistant Medical Examiner  | 111 Penn Street, Baltimor         | e, MD 21201  |
| 31. Date filed (Monto, Day Year) 7 2010 32. Registrar's Signature S. Saa   | MI                                |  |
|  |                                   |  |

State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                  | State of Maryland / Department / Department of Maryland / Department / De | artment of Health and  |   | 71111                      | 12720   |
|--|------------------|--|--|---|----------------------------|---|
|  |                  | 1. Decedent's Name (First, Middle, Last)   | incate of Death  | 2. Date of Dea                              | Reg. No.                   | 3. Time of Death                              |
| Physici  |                  |  |  | Month                                       | 05 2010                    |   |
| Medi   |                  | Charles Edward Hall, Jr.  4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location of Deat  | 04  |                            | 8:45p M                                       |
| Exami  | ner              | Washington Adventist   | Takoma Park  | .rı   | 4c. County of Death        |   |
| Funeval  | ,                |  | If Under 1 Year   If Under 24 Hrs  | 8. Date of Birt                             |                            | hplace (State or Foreign                      |
| Funeral<br>Director  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 G F 82 Yrs.  | Months Days Hours Min  |   | Year) Col                  | nington, DC                                   |
|  |                  | Usual Residence of Decedent  |  | 100 10 1                                    | .921 [Wasi                 | illigion, DC                                  |
| and<br>shov  | ō                | 10a. State 10b. County 10c. City, Town or Lo   | cation   |   |                            | 10d. Inside City Limits                       |
| faryk<br>3a-f  | ect              | MD Prince Georges College Pa   | 1-   |   |                            | 1X☐ Yes 2 ☐ No                                |
| the h  | □                | 10e. Street and Number   | 10f. Zip Code  |   | 10g. Citizen of What Co    | untry?  |
| with<br>23a<br>1st b   | era              | 3515 Duke Street   | 20740  |   | IICA                       |   |
| eath eath  | Funeral Director |  | Was Decedent of Hispanic Origin? (S<br>f Yes, specify Cuban, Mexican, Puer         | pecity Yes or No-                           | 14. Race - Amer            | ican Indian.                                  |
| er de<br>mine  | b y              | Armed Forces?  |  | to Rican, etc.)                             | Black, White               |   |
| s aft<br>ral",<br>Exa  |                  | 1 Never Married 2 X Married 1 X Yes 23 War 1946—<br>3 Widowed 4 Divorced 1 Yes, Give 23 War 1946—<br>Year or Dates 28 Jan 1947   | 1 ☐ Yes 2 🔀 No Specify:  |   | Specify: Whi               | te  |
| 3-UU30<br>hours after<br>"natural", o<br>dical Exam  | Completed        | 15. Decedent's Education 16a. Decedent   | dent's Usual Occupation  |   | 16b. Kind of Business I    | ndustry                                       |
| in 72<br>e.<br>an "  | ١Ĕ               | )/6- 0   | kind of work done during most of wo<br>O NOT use retired)                          | rking                                       |                            |   |
| with gien the  |                  | Elementary/Seconday (0-12) College (1-4 or 5+) Audi  | tor  |   | Federal                    |   |
| filed<br>al Hy<br>doth<br>vent   | B B              | 17. Father's Name (First, Middle, Last)  | 18. Mother's Na  | me (First, Middle, i                        | Maiden Surname)            |   |
| d be dent dent dent dent dent dent dent den  | <u>ا</u>         | Charles Edward Hall  | Ellen Ja   | ane Dunca                                   | ın                         |   |
| ary<br>hould<br>and h  |                  | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir   | ng Address (Street and Number or Ri  | ural Route Number                           | ; City or Town, State, Zip | Code)   |
| d 2 salth allth 27 in  |                  | Betty V. Hall / Wife 3515  | Duke Street Col  | lege Parl                                   | c, MD 20740                |   |
| Datumore, IMaryliand ZIZIO-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   |                  | 20a. Method of Disposition 20b. Place of Dispo   | sition (Name of  | Date  | 20c. Location - City or    | Town, State                                   |
| age<br>ent c<br>nt: If   |                  |  | natory or other place) 1n Crematory 04,  | /13/2010                                    | Rrantwood N                | m   |
| DENTITION  Department of popular of mportant: If it any injury or one  |                  |  | Name and Address of Facility $Ft$  |   |                            |   |
| Departmine Department on the once.   |                  |  | 01 Bladensburg R   |   |                            |   |
|  |                  | 23a. Part . Enter the disease, or complications that caused the death. Do not enter  |  |   |                            | 7 Z Z<br>Approximate                          |
|  |                  | shock, or heart failure. List only one cause on each line.   |  | o o o o o o o o o o o o o o o o o o o       |                            | Interval Between<br>Onset and Death           |
| ⊸Pnysician/<br>Medical   |                  | disease or condition a.  | Edlina   |   |                            |   |
| Examiner   |                  | Due to (or as a consequence of):   | dillicito  | caliti                                      | -, ·                       |   |
|  | ē                | Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):   | appear !   | oun   | 5                          |   |
| sit sd   | ]듩               | cause Enter Underlying   | alteria dia  | 0 2000                                      |                            |   |
| ecute<br>and<br>-tran  | Examiner         | Cause (Disease or ilinjury that initiated events resulting in death) Last c. Due to (or as a consequence of):  | wind our   | llise                                       | -                          |   |
| te be executed ysician and ne burial-transi  | al               | 0 +  | 1  |   |                            |   |
|  | dical            | d. Payoud C  | Lar ar   |   |                            |   |
| of Attending Physician: The law requires that the death certification and Attending Physician: The law requires that the death certification and the death certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the page of the control of t | sician/Me        | IF FEMALE:   |  |   |                            |   |
| th ce  | ian              | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3  |  |   | 23d. Date of deli<br>Month | very<br>Day Year                              |
| dea dea  | /sic             | 1   Yes 2   No 4   Pregnant at time of death 5   9   Unknown   | Other (specify)  |   | Widitii                    | Day Teal                                      |
| es that the designed by the a  | Phy              | Part II. Other significant conditions contributing to death but not resulting in the u   | nderlying cause given in Part I  | 020 Did to                                  | bacco use contribute to    | the squae of death?                           |
| es the   | by               | Taren Sully Significant Solidation Solidating to double but not recently in the d  | inderlying dadde given in raire.   |   |                            |   |
| v requires<br>been signatured<br>should to   | Completed        |  |  | 1 🗆 Y                                       | ′es 2 ☐ No 3 ☐ Pr          | obably 4 🕰 Unknown                            |
| aw re<br>as be   | ) ple            |  |  | 24a. Was a<br>autop                         | sy prior to d              | opsy findings available ompletion of cause of |
| The law cate has page 2 s  | ĮŞ.              |  |  | perfor                                      | med? death?                | 2 🗆 No  |
| ysician: The nis certificate director, pag   | Be (             | 25. Was case referred to medical examiner?   | 26. Place of Death (Che  |   |                            |   |
| nysic<br>nis ce<br>dire  | 2                | 1 ☐ Yes 2 ▼ No Hospital: 1 🕅 Inpatient 2 ☐ ER/Outpatier  | nt 3 DOA Other: 4 Nursing I  | Home 5 Resid                                | ence 6 Other (Speci        | fy)   |
| ding Ph<br>h.<br>After th<br>funeral   | ij               | 27. Manner of Death 1 ∑ Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury   | 28c. Injury at work?   | 28d. Describe ho                            | ow injury occurred         |   |
| endir<br>eath.<br>or: Af   | Certificate:     | 2 Accident Investigation   | M 1 Yes 2 No   |   |                            |   |
| r Att  | erti             | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streaming building, etc. (Specify)  | eet, factory, office   | 28f. Location (Si<br>City or Town           | treet and Number or Rur    | al Route Number,                              |
| ed in all controls   |                  | building, etc. (Specify)   |  | City or Town                                | i, State)                  |   |
| ospi<br>hou<br>uner  | dic              | 29a. Certifier  Charles  Charl | occured at the time, date and place,   | and due to the cau                          | se(s) and manner as sta    | ted.  |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attention completed filled in by the fune   | Medical          | (Check 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practioner: To the best of my knowledge, or  | ligation, in my opinion, death occurred<br>death occurred at the time, date and pl | at the time, date ar<br>ace, and due to the | cause(s) and manner as     | ause(s) and manner stated.<br>stated.         |
| To t<br>To t   |                  | 29b. Signature and title of certifier  | 29c. License number  | 2   | 29d. Date signed (Month    | , Day, Year)                                  |
|  |                  | · Cladre M   | D D6383  | 9   | 4/6/11                     | 9   |
| 10   |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, F  |  | ,   | 11-1-                      | -   |
| _10  |                  | Dr. Padma Chirumamilla 7600 Carroll  | Avenue Rm. 5100  | Takoma P                                    | ark, MD 209                | 12  |
| Sta  |                  | 31. Date filed (Month, Day, Year) 32. Registra's Signature   |  |   |                            |   |
| Registr  | ar               | APR 0 9 2010 Centry B. Market  |  |   |                            |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| in,      | 1 | 1   | ,  | 2 | -   | $\cap$ |
|----------|---|-----|----|---|-----|--------|
| 1        | 7 |     | f. | / | - [ | ./     |
| Forester | 1 | 1 6 | J. |   | 1   | 6-     |

|   |               | 1- For State Registrar Ce  | rtificate of Death  |                           |                                     | Re                                  | g. No.  | 0 212                                     |
|---|---------------|--|---|---------------------------|-------------------------------------|-------------------------------------|---|---|
| Physic  |               |  |   |                           |                                     | 2. Date of Death<br>Month           |   | 3. Time of Death                          |
| Medical Exam  | ine           | THETMA HICKEHDOLLOM  |   |                           |                                     | March 30,                           | 2010  | 0825 hrs                                  |
|   |               | Facility Name (if not institution, give street and number)     Prince George's Hospital Center                                 | 4b. City, Tow<br>Cheverl  |                           | ation of Death                      |                                     | 4c. County of Deat<br>Prince Georg                |   |
| Funeral   |               | 5. Social Security Number 6. Sex 7. Age (In yrs. I   |   |                           | f Under 24Hrs.                      | 8 Date of Birth                     | (MM/DD/YYYY) 9. Bir                               |   |
| Director  |               |  | Months  |                           | Hours Min.                          | 1                                   | Forei   |   |
|   |               | 218-86-3041 1 M 2 X F 46  Usual Residence of Decedent  | Yrs.  |                           |                                     | rial Cli 2                          | .0, 1904  | Juliuy) DC                                |
| any   |               |  | Town or Location  |                           |                                     | · · · ·                             |   | 10d. Inside City Limits                   |
| nd<br>show  | =             | Maryland Prince George's   |   | Land                      | lover                               |                                     |   | 1 X Yes 2 No                              |
| faryla<br>28a-f:<br>aton  | Director      | 10e, Street and Number   | 10f. Zip Co   | ode                       |                                     | 10                                  | g. Citizen of What Cou                            | ntry?                                     |
| the M<br>a or 2   | <del>`</del>  |  | 5   | 20785                     |                                     |                                     | United St   | ates                                      |
| ath with the Maryland<br>items 23a or 28a-f show any<br>ast be notified at once.  | Funeral       | 11. Marital Status 12, Was Decedent Ever in U.   | S. 13. Was Decedent of  | of Hispani                | ic Origin? (Spe                     | cify Yes or No-                     | 14, Race - Amer                                   | ican Indian, Black                        |
| death<br>or ite   | ŭ,            | 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No   | If Yes, specify C   | uban, Me                  | xican, Puerto F                     | (ican, etc.)                        | White, etc.                                       |   |
| s after<br>ral",<br>viner   | by            | 3 Vidowed 4 Divorced lif Yes, Give Year or Dates:  | 1 Yes 2 X   |                           | -                                   |                                     |   | ack                                       |
| hour:   | ted           | Decedent's Education (Specify only highest grade completed)     Elementary/Secondary (0-12)     College (1-4 or 5+)            | 16a. Decedent's Usual Occ<br>during most of working                               |                           |                                     |                                     | 16b. Kind of Business/                            | Industry                                  |
| 36<br>uin 72<br>e.<br>than<br>dical   | Completed     | Elementary/Secondary (0-12) College (1-4 or 5+)  | Care  | Drow                      | idor                                |                                     | Governm   | ent                                       |
| d with  | l oc          | 17. Father's Name (First, Middle, Last)  | Care  |                           |                                     | First Middle Ma                     | aiden Surname)                                    | enc                                       |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica  | Be (          | John L. Henry  |   |                           |                                     | ily M.                              |   |   |
| Ould I  | <b>To</b> 1   | 19a. Informant's Name/Relationship (Type, Print )  | 19b. Mailing Address (  | Street and                |                                     |                                     |   | , Zip Code)                               |
| s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Montal Hygene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medisal Examiner must be notified at once   |               | Keith Hickenbottom/ Husband  | 3233 75th A   |                           |                                     | 204 L                               | andover, M  | d. 20785                                  |
| nore, MD 21215-0036 sges 1 and 2 should be filed within 72 hours after death with the Maryland and of Fleath and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at once.                                      |               |  | Place of Disposition (Name or<br>prematory or other place)                        | of cemeter                | y, Apri                             | I 5,                                | 20c. Location - City or                           | Town, State                               |
| Page<br>nent o  |               |  | Heritage Ceme   | etery                     | _                                   |                                     | Waldorf   | , Maryland                                |
| Baltimore, MI permit. Pages I and 2.9 Department of Health a Important: If item 27 injury or other traum  | ľ             | 21. Signature of Funeral Service Licensee  | 22. Name and Add  | dress of F                | acility Stev                        | art Fur                             | neral Home,                                       |   |
|   |               | MANNY STORESTAM  |   |                           |                                     |                                     | ngton, DC   | 20019                                     |
| Physician<br>/M   |               | 23a Part I. Enter the disease, or complications that caused the death.   | Do not enter the mode of dy   | ying, such                | as cardiac or r                     | espiratory arres                    | t, shock, or heart                                | Approximate Interval<br>Between Onset and |
| Examiner  |               | Immediate Cause (Final disease or condition resulting in death)  Bilateral Pulmonary Thr  Due to (or es a consequence of       |   |                           |                                     |                                     |   | Death                                     |
|   |               | Sequentially list conditions,  | •   | mboses                    | 5                                   |                                     |   |   |
|   | je.           | if any, leading to immediate  cause. Enter Underlying Cause  | ):  |                           |                                     |                                     |   |   |
|   | Examiner      | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of                              | ):  |                           |                                     |                                     |   |   |
| uted<br>nd<br>ransit  |               | d.   | ,   |                           |                                     |                                     |   |   |
| 760,<br>Ticate be executed<br>g physician and<br>the burial - transit   | /Medical      | UNPENDED AMENDED   |   |                           |                                     |                                     |   |   |
| 760, icate be physici the buri  | Š.            | IF FEMALE: 23c. If yes, outcome of pregr   | ancy  |                           |                                     |                                     | 23d. Date of delivery                             | 1   |
|   |               | past 12 months?  | 2 Fetal death   | 3 <b>E</b> c              | topic pregnanc                      | У                                   | Month D   | ay Year                                   |
| Box 68<br>death certif<br>he attending<br>d for use as  | Physician     | 1 Yes 2 No 9 V Unknown Pregnant at time of dea   | 5 Other (Specify)   |                           |                                     |                                     |   |   |
| O. B.<br>at the de  |               | Part II. Other significant conditions contributing to death but not re   | sulting in the underlying cau   | se given i                | in Part I.                          | 23e. Did toba                       | Lacco use contribute to t                         | he cause of death?                        |
| rds, P.O. requires that the been signed by tould be detach  | Completed by  | Obesity  |   |                           |                                     | 1 Yes                               | 2 No 3 Prob                                       | ably 4 🗸 Unknown                          |
| ords<br>w requir  | e<br>e        |  |   |                           |                                     | 24a. Was an autopsy                 |   | opsy findings available                   |
| Reco<br>The law<br>icate has  | Ĕ             |  |   |                           |                                     | perform                             | ed? death?  |   |
| tal Recian: The   |               | 25. Was case referred to medical   | 26.P  | lace of De                | eath (Check on                      |                                     | No 1 Yes  | s 2 No                                    |
| Vital   hysician: this certifi  | o Be          | examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 1  | ER/Outpatient 3 DOA   | Other                     | 4 Nursing I                         | lome 5 Re                           | esidence 6 Other.                                 |   |
| Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be  | آڃَ           | 27. Manner of Death  1 V Natural 5 Panding  28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury 28c.  | Injury at V               | Vork? 28                            | 3d. Describe how                    | w injury occurred                                 |   |
| ttend<br>death.<br>ctor:  | lä:           | Natural 5 Pending 2 Accident Investigation   | 1[  | Yes 2                     | 2 No                                |                                     |   |   |
| ivis<br>lor A<br>after<br>Dire  | ertification: | Suicide Could flot be  | me, farm, street, factory, office   | ce buildin                | g, etc. 28                          | Bf. Location (Street or Town, State | eet and Number or Run                             | al Route Number, City                     |
| ospita<br>hours<br>ineral   | O F           | 4 Homicide determined (Specify)  29a. Certifier 4 Out 1 Specify  |   |                           |                                     |                                     |   |   |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | edical        | (Check only one)  1 Certifying Physician: To the best of my knowledge one)  2 Medical Examiner: On the basis of examination an | <ol> <li>death occurred at the time<br/>d/or investigation, in my opin</li> </ol> | e, date and<br>nion, deat | d place, and du<br>h occurred at th | e to the cause(s                    | s) and manner as state<br>d place, and due to the | d.<br>cause(s)                            |
| To To com   | Neg-          | and manner stated.  29b. Signature and title of certifier  |   | ense num                  |                                     |                                     | 9d. Date signed (Mon.                             |   |
|   |               | Dat . (1000) 200   | _   | C.M.E.                    |                                     |                                     | March 31, 2010                                    | , - 2,, . 561,                            |
| 1 2   | }             | 30. Name and address of person who completed cause of death (Item 2  | <i>y</i> = <i>J</i> •   |                           |                                     |                                     |   |   |
| 123   |               | Patricia Aronica-Pollak MD. Assistant Medical E  | xaminer 111 Penn  | Street,                   | Baltimore,                          | MD 21201                            |   |   |
|   |               | 31. Date filed (Month, Day, Year) 32. Registrar's Sinature   | harles  |                           |                                     | _                                   |   |   |
| Regist  | rar           | APR 0 9 2010 Rema B. 15  | F   |                           |                                     |                                     |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 2,8,29d per dr. g912 24 [tificate of Death 2. Date of Death .5., 10 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 0520 AM Ashton Dwight Hawks January 15 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth 1/5/10 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X**M 2□ F NONE January 15 2010 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show citical Examiner must be notified at 1 Yes 2 No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with us 21223 2731 Fairmount Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Black Specify: ģ 3 Widowed 4 Divorced Completed er than "natura; the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 is marked other than " r traumatic event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) None Infant NONE Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrea Geter Anthony Dwight Hawks မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21223 Health am 27 is Avenue Baltimore, Md. 2731 Fair mount item 27 other t Andrea Geter / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ₹ Department of important: if it any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 7, 2010 Bultimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral 22. Name and Address of Facility SAINT AGNES HOSPITAL 21. Signature of Funeral Service Licenses 900 CATON AVENUE BALTIMORE, MD Long 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Extreme Prematurity disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1X Inpatient Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Less Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. To the I within 2. 29d. Date signed (Month Day Oear) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON 100

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month,

Day,

Registrar's

|                            |  |                  | State Registrar  |   | Ce                           | rtificate of   | Death                       | •                                       | Reg. No.                               |  |
|----------------------------|--|------------------|--|---|------------------------------|--|-----------------------------|---|--|--|
|                            | Dhysia   | ian              | 1. Decedent's Name (First, Middle, Last)   |   |                              |  |                             | 2. Date of De                           | ath                                    | 3. Time of Death                                     |
|                            | Physic<br>Med/   |                  | Morris Emory Johns   | on, Sr.   |                              |  |                             | APRIL                                   | a ac                                   | Year 11:10 PM  |
|                            | Exami  | ner              | 4a. Facility Name (If not institution, give st   |   |                              | 4b. City, Town, o  | r Location of Dea           |   | 4c. County                             |  |
| 1                          |  |                  | CIVISTA MEDIC  |   |                              | LA PL  | ATA.                        |   | CHI                                    | ARLES  |
|                            | Funeral<br>Director  |                  | 214-03-0302  | 7. Age (In yrs. In 94   | ast birthday,<br>Yrs.        | If Under 1 Year<br>Months Days                             | If Under 24 Hr<br>Hours Mir |   | y, Year)                               | Birthplace (State or Foreign Country)     Virginia   |
|                            | and  |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c City  | , Town or Lo                 | ocation  |                             |   |  | 10d. Inside City Limits                              |
|                            | Maryl<br>f sho   | ō                | Maryland Charles   |   | dian :                       |  |                             |   |  | 11 Yes 2 □ No  |
|                            | the t  | rec              | 10e. Street and Number   |   | idiaii .                     | 10f. Zip Code  |                             |   | 10g. Citizen of W                      |  |
|                            | death with the Maryland<br>ims 23a or 28a-f show<br>imst be notified at  | Funeral Director | 24 Kenwood Place   |   |                              |  | 0640                        |   | U.S.A                                  |  |
|                            | ms 2   | Jera             |  | 2. Was Decedent Ever in U.S   | 3. 13.                       |  |                             | Specify Yes or No.                      |  | a - American Indian,                                 |
| 5-0036                     | ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Expendence must be notified at | þ                | 1 ☐ Never Married 2 🔀 Married<br>3 ☐ Widowed 4 ☐ Divorced  | Armed Forces?<br>1 XYes 2 No<br>If Yes, Give WWII<br>Year or Dates: WWII                                  |                              | Was Decedent of I<br>If Yes, specify Cub<br>1 □ Yes 2 ☆ No |                             | rto Rican, etc.)                        |  | white, etc.  |
| 5-(                        | 72 h<br>'natu  | Completed        | 15. Decedent's Educa<br>(Specify only highest grade  | ation<br>completed)   | 16a. Dece                    | dent's Usual Occup   | pation                      | orkina                                  | 16b. Kind of Bus                       | siness/Industry                                      |
| 121                        | within<br>iene.<br><b>than</b> "   | ם                | Elementary/Secondary (0-12)  | College (1-4or 5+)  | life.                        | DO NOT use retire  | d)                          | , ming                                  |  |  |
| 121                        | filed w<br>Hygie<br>other t  |                  |  |   | Filgh                        | t Instruc  |                             |   |  | overnment  |
| Maryland                   | ould be f<br>Mental I<br>arked ot<br>atic evel   | Be               | 17. Father's Name (First, Middle, Last)  Morris Johnson  |   |                              |  | _ ,                         | me (First, Middle,                      | Maiden Surname                         | ,)   |
| Ž                          | should<br>and Mer<br>marke<br>umatic   | 2                | 19a. Informant's Name/Relationship (Type   | - Delan   | 101 11 11                    |  |                             | Hall                                    |  |  |
| Z                          | d 2 sho<br>Ith and<br>?7 is ma<br>trauma   |                  | Jean B. Johnson  | Wife  |                              | ng Address (Street   |                             |   |  |  |
| 6                          | Health<br>tem 27   | -                | 20a. Method of Disposition   |   |                              | enwood Pl  |                             | Date Head                               |  | J64U<br>City or Town, State                          |
| Baltimore,                 | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any Injury or other<br>once.   |                  | 1 🕅 Burial 2 □ Cremation 3 □ Rei<br>4 □ Donation 5 □ Other (Specify)   | moral from Otalo  | nity M                       | osition (Name of<br>matory or other plan<br>Memorial       | Gardens                     | 7, 2010                                 |  | _Maryland  |
| Bal                        | perm<br>Depa<br>Impo<br>any Is   |                  | 21. Signature of Funeral Service Licentee  |   | 68 42                        | 2. Name and Addre<br>111iams F<br>270 Hawth                | uneral H<br>orne Rd.        | ome, P.A<br>, Indian                    | Head, M                                | -  |
|                            | Physician<br>//Medical<br>Examiner   |                  | 23a. Part1. Enter made, ase, or complica shock, or heart failure. List only one Immediate Cause & Inal disease or con thou resulting in death) | ations that ca'ved the death.<br>cause in each line.  Due to (or as a consequence                         | atic                         | er the mode of dyi   | ng, such as cardia          | ac or respiratory ar                    | rest,                                  | Approximate<br>Interval Between<br>Onset and Death   |
|                            | ted<br>isit  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.             | Due to (or as a consequ   | snee of):                    |  |                             |   |  |  |
|                            | certificate be executed ding physician and se as the burial-transit  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last  |   |                              |  |                             |   |  |  |
| 60,                        | ficate be execute<br>physician and<br>s the burial-trans   | <u></u>          | resulting in death) Last   | Due to (or as a conseque  | ence of):                    |  |                             |   |  |  |
| 68760,                     | cate<br>physi<br>the t   | /Medical         | d.   |   |                              |  |                             |   |  |  |
| O. Box                     |  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | c. If yes, outcome of pregnan<br>1 ☐ Live birth 2 ☐ Fetal of<br>4 ☐ Pregnant at time of de<br>9 ☐ Unknown | death 3[                     | Ectopic pregnand Other (specify)                           | у                           |   | 23d. Date<br>Mon                       | of delivery<br>th Day Year                           |
| rds, P.                    | ä .⊡.ĕ   | <u>م</u>         | Part II. Other significant conditions contri   | buting to death but not resul   | ting in the u                | nderlying cause giv  | en in Part I.               | V                                       |  | bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown |
| S                          | w requir<br>s been s<br>should   | lete             |  |   |                              |  |                             | 24a. Was a                              | 24h W                                  | ere autopsy findings available                       |
| al Re                      | The<br>ate h   | Completed        |  |   |                              |  |                             | autop:<br>perfor                        | sy pr<br>moęd2r' de                    | rior to completion of cause of eath?                 |
| Ĭ,                         | nding Physiclan:<br>th.<br>: After this certifics<br>? funeral director, p   | Be               | 25. Was case referred to medical examiner?   | spital:   |                              | Oth  | or:                         | ath (Check only or                      |  |  |
| of                         | Phys<br>r this<br>ral di   | ا<br>ا           | 1 Yes 2 No   | 18 Inpatient 2 E  | R/Outpatier<br>28b. Time of  |  | 4 Li Nursing i              | Home 5 Resid                            |  |  |
| on                         | ding<br>th.<br>: Afte<br>: fune  | tion             | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day, Year)  | Injury                       | 28c. Injur<br>Worl   | yaı<br><br Yes 2 ∐ No       | 28d. Describe h                         | ow injury occurred                     | d  |
| Division of Vital Records, | To the Hospital or Attending Pl<br>within 24 hours after death.<br>To the Funeral Director: After the<br>completely filled in by the funeral   | Certification:   | 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Injury - At hom<br>building, etc. (Specify)   | ne, farm, stre               |  | 165 2 110                   | 28f. Location (S<br>City or Tow         | treet and Number<br>n, State)          | r or Rural Route Number,                             |
|                            | e Hospita<br>24 hours<br>E Funeral<br>etely fille  | Medical C        | 29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine   | tian: To the best of my know<br>r: On the basis of examination  | ledge, death<br>on and/or in | occurred at the tile<br>vestigation, in my co              | me, date and place          | e, and due to the ourred at the time, o | cause(s) and mar<br>date and place, ar | nner as stated.<br>nd due to the cause(s)            |
|                            | To th<br>within<br>To the  | ₩                | 29b. Signature and little of certifier   |   |                              | 29c, Licens  | e number                    | 2                                       | 29d. Date signed                       | (Month, Day, Year)                                   |
|                            | BBIL   |                  | > (/Villan   | MIN   |                              | Dor  | 26165                       | 2                                       | 04/1                                   | 03/2010  |
|                            | lat \  |                  | 30. Name and address of person who comp  | pleted cause of death (Item 2   | 23a) (Type,                  | Print)   | 1 10                        | A 40.                                   | dhall                                  | MU 201-2   |
|                            | Sta  | te               | 31. Date filed (Month, Pay, Year)  | 32. Registrar's Signatu   | ire b                        | 105401   | pru k                       | 0,000                                   | That I                                 | 1111, 20003  |
|                            | Registr  | ar               | APR US ZU  | U Persus  | A A                          | 1 to Kal   |                             |   | -1                                     |  |

DHMH 17 Rev 1/2001

#15123

E, JOHNSON SIZ

MORRIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #10b 1 - For State Registrar 4/13/2010, M.S., Kent Co. Certificate of Death 2. Date of Death 3. Time of Death Physician/ April 2010 Ralph Kennard Jackson 11:45P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kent Chestertown Nursing & Rehab Chestertown If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 3/24/1922 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MD Country) **Funeral** 1**X**□ M 2 □ F Hours Director 88 217-36-0753 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Caroline, een Anne Goldsboro 1X Yes 2 ☐ No MD <del>Queen</del> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21636 300 Church Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julia Ann Hay Harvey A. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Church Lane Goldsboro, MD 21636 Ralph Jackson Jr. /Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sudlersville Cemetery 4/9/2010 Sudlersville, MD 21. Signature of Funeral Service License 2. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 370 W. Cypress St. Millington, MD 21 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titleof certifier 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vasir Kamin orth main 31. Date filed (Month State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 2010 11:14pM Saundra Kay Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours Min. Mary Land 234-58-1221 **Director** Usual Residence of Decedent 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince Georges College Park 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4901 Nantucket Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Norma Jean Jones Robert Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, MD 21113 Kimberly D. Steir/ Cousin 1314 Saran Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 04/12/10 Brentwood, MD Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Fun all Service License 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Ph\_sician/ Medical Examiner

show

28a-f

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items 23a

'natural", or

al Hygiene.

and Mental Fisher is marked or

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Be ျှ

Certificate:

Medical

State Registrar 27. Manner of Death Natural 5 Pending 2 Accident
3 Suicide
4 Homicide

2 No

1 Yes

29a. Certifier

(Check

Investigation 6 Could not be determined

28a. Date of injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

1 Inpatient 2 ER/Outpatient 3 I DOA

28b. Time of

injury

29c, License number D 40324

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

work?

2 🗌 No

28c. Injury at

29d. Date signed (Month, Day, Year)
APRIL 5, 2-010

MARYLAND

28f. Location (Street and Number or Rural Route Number,

4 Nursing Home 5 Residence 6 Other (Specify)

City or Town, State)

TAROMA PARK

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVENUE TERRY JODRIE MO FACEP

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

**Funeral** Director "natural", or items 23a or 28a-f shov edical Examiner must be notified at within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 dimore, ...

nit. Page 1 and 2 should be filed www...

radment of Health and Mental Hygiene.

""am 27 is marked other than "natural",

""atic event, the Medical Ex permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Physician/ Medical Examiner the burial-transit attending physician Box 68760 use as signed by the at d be detached for P.O. Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Marjorie Elinor Johnson April 8 2:30 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9916 McIntosh Drive Calvert Dunkirk If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days 06-29-1931 Massachusetts 021-24-5038 78 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No MD Calvert Dunkirk 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9916 McIntosh Drive 20754 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) restaurant manager and owner food services Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilfred King Mabel Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Teresa Del Casino, daughter</u> 9916 McIntosh Drive, Dunkirk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 04-12-2010 | Crownsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Metastatic lung cancer disease or condition resulting in death) months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Probably 4 Unknown Chroni obstrative lung disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page Breast cancer 2 🗌 No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 440 ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12146 Ullma ms 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lew 5 4801 Dorsey Hall Dr., Ste. 201, Ellicott City, MD Parry A. Moore, M.D. 31. Date filed (Month, Day, Year) 32. Registra s Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 7/2009

Registrar

of Vital

Division

2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Genevieve Dolores Kemp March 29, 2010 08:00A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frostburg Village Nursing Care Center Allegany Frostburg 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 234-38-8138 Director 85 October 21, 1924 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Allegany Maryland Frostburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or in marked other than "natural", or Items 23a or in any Injury or other traumatic event, the Medical Event is at must be apply injury or other traumatic event, the Medical Event is at must be apply injury or other traumatic event, the Medical Event is at must be applyed. 67 South Water Street 21532-U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manager/owner hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Lester O. Brenneman Janette Hayes ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kip Ellifritz nephew Route 6, Box 6667 Kevser West Virginia 26726-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Frostburg Memorial Park April 03, 2010 4 Donation 5 DOther (Specify) Frostburg Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenseg Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVAS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dust to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 🖺 Yes 2 No 3 Probably 4 dnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an s certificate has be lirector, page 2 sl autopsy 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗆 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 26907 10

DHMH 17 Rev 1/2001

State Registrar idhy

31. Date filed (Month, Day, Year)
MAR 3 1 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:58 AM Physician/ ABOULLAH , KHAN 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMOKE UNIVERSITY OF MARYLAND MEDICAL CENTER 8. Date of Birth Month Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 58 1 🗙 M 2 🗆 F 1952 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 10b. County within 72 hours after death with the Maryland Director 1 🗆 Yes 2 📉 No Boonsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21713 AKISTAN Funeral items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status "natural", or iter edical Examiner Black, White, etc. 1 Never Married 2 Married þ Asian Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Education College (1-4 or 5+) Elementary/Seconday (0-12) Teaching 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) KHATOON  $M \cdot KHAK$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MEHRULL BROTHER Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition PAKISTAN Burial 2 Cremation 3 Removal from State 14/2010 any injury or NOSHKI 10SHK1 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner tungemia Sequentially list conditions, if any, leading to immediate Due to or as a consequence of) Cause (Disease or linjury neutroperia and burial-trar that initiated events resulting in death) Last anding physician use as the burial Physician/Medical AML the Hospital or Attending Physician: The law requires that the death certificate be P,O. Box 68760 attending IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No been signed by the s should be detached 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 XNo 2 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be Other: MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After Natural 5 Pending 1 Yes 2 No Investigation Accident 2 Accident
3 Suicide
4 Homicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check wedical examiner. Or the basis of examiners or action and best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) 2010 24355 ANDREA HUANG M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

DHMH 17 Rev 7/2009

State

S. EUTA W

APR 1 2 2010

31. Date filed (Month, Day, Year)

ST. # 919

MD

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me,g902,04/23/2010dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D Year 20 12:12 PM Nanc Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) 228-97-2783 1 □ M 2 🖾 F Hours (Month, Day, Year Director 2 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No FairFa 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Funeral Vietna 22/52 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Aslan 1 Yes 2 No Specify 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shop Tech NaiL any injury or other traumatic event, once, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Nhiem I EN Ngo 19a. Informant's Name/Relationship (Typ , Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HA Springf oma ane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State -15-10 Alexandria Metropolitan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Home 22066 Junson 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrhau navaco disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any Leoling to irrandiate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to for as a nonsequence of DBY N YEAR EXAMINER the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last CERTIFICAT P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records. 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No Division of Vítal the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Graph Thying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗆 within 2 To the I only one) 29b. Signature and tit

Registrar

State

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etown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sigr

31. Date filed (Month, Day, Year)

2010

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|                   |  |                     | For<br>State<br>Registrar   | State of Ma  | aryland / Depa  | artment of H<br>rtificate of                              |                 | d Mental Hy                                | giene<br>Reg. No.                  | 10                                       | 12730  |  |
|-------------------|--|---------------------|---|--|---|---|-----------------|--|------------------------------------|--|--|--|
|                   | Physici  | an                  | Decedent's Name (First, Middle, Las     DONALD LEE LUHN   |  |   |   |                 | 2. Date of De<br>Month<br>APRIL            | Day                                | Year                                     | 3. Time of Death  10:59 A <sup>M</sup>             |  |
| }                 | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give   | street and number)   |   | 4b. City, Town, o   | r Location of D |  |                                    | 4c. County of Death                      |  |  |
|                   |  |                     | 21609 Second Stre   |  |   |   | onsvill         |  |                                    | Montgo                                   |  |  |
|                   | Funeral<br>Director  |                     | 5. Social Security Number 6. Sec. 220–12–3513   | X 7. Agi<br>XM 2□F   | e (In yrs. last birthday)<br>89 Yrs.                      | If Under 1 Year<br>Months Days                            |                 | Ain. (Month, Da                            | th<br>ay, Yea <i>r)</i><br>12 1921 | Cou                                      | place (State or Foreign<br>intry)<br>rvland        |  |
|                   | pu *   |                     | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or Lo                                     | cation  |                 |  |                                    |  | 10d. Inside City Limits                            |  |
|                   | Maryla<br>f shot   | jo                  | Md. Montgo  | mery   |   | sville  |                 |  |                                    |  | 1 XYes 2 No  |  |
|                   | th the   | lrec                | 10e. Street and Number  |  |   | 10f. Zip Code   |                 |  | 10g. Citizen                       | of What Cou                              | untry?   |  |
|                   | ath wi   | ral                 | 21609 Second Stre   |  |   | 208   |                 |  |                                    | ited S                                   |  |  |
| 21215-0036        | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other than "naturel", or Items 23a or 28e-f show or other treumatic event, the Medical Examinar must be notified at or other treumatic event, the Medical Examinar must be notified at | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent<br>Armed Forces?<br>1 → Yes 2 → N<br>If Yes, Give<br>Year or Dates: | Everin U.S. 13.   | Was Decedent of H<br>f Yes, specify Cub<br>1 ☐ Yes 2 🗵 No |                 | ? (Specify Yes or No<br>uerto Rican, etc.) |                                    | Race - Ameri<br>Black, White<br>ecify: W |  |  |
| 5-0               | "natur   | letec               | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de completed)   | (Give   | dent's Usual Occup  | during most of  | working                                    | 16b. Kind o                        | of Business/Ir                           | ndustry  |  |
| 121               | iene.  | Completed           | Elementary/Secondary (0-12)   | College (1-4or 5   | i+)   | DO NOT use retire<br>vy Equipm                            |                 | erator                                     | Cor                                | unty R                                   | oads   |  |
| nd                | d 2 should be filed within h and Mental Hygiene. 7 is marked other than "treumatic event, the Med  | Be                  | 17. Father's Name (First, Middle, Last)   |  |   | 7 1   |                 | Name (First, Middle                        | , Maiden Sui                       |  |  |  |
| Maryland          | d Ment<br>marked<br>matic  | P                   | Leslie Luhn  19a. Informant's Name/Relationship (7)   | Const. China   | 1(h 14-iii  | and drawn (Change   | Anni            | Le Leather Route Number                    |                                    | Ctoto 7                                  | in Code)   |  |
| Ma                | nd 2 si<br>lith an<br>27 is r<br>r treur   |                     | Izetta J. Luhn /  |  |   |   |                 | Layton:                                    |                                    |  | 20882  |  |
| Baltimore,        | es 1 a<br>of Hea<br>fitem<br>rothe   |                     | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐   | Removal from State   | 20b. Place of Dispo<br>cemetery, crea                     | sition (Name of<br>matory or other pla                    | сө)             | Date                                       | 20c. Locati                        | ion - City or T                          | Fown, State  |  |
| ţ                 | t. Pag<br>rtment<br>rtent: I   |                     | `4 ☐ Donation 5 ☐ Other (Specify  | onsvil   | le, Md.   |   |                 |  |                                    |  |  |  |
| P.                |  |                     |   |  |   |   | ox 5038         | er Funera<br>B, Laytons                    | sville                             | , Md.                                    | 20882  |  |
|                   |  |                     | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only<br>Immediate Cause (Final      | lications that caused<br>one cause on each li  | the death. Do not en                                      | er the mode of dyir                                       | ng, such as car | diac or respiratory a                      | arrest,                            |  | Approximate<br>Interval Between<br>Onset and Death |  |
|                   | Physician<br>/Medical  |                     | disease or condition resulting in death)  |  | nic Renal la consequence of):                             | Tailure   |                 |  |                                    |  | Years  |  |
|                   | Examiner   |                     | Sequentially list conditions.   | b. Diabe   | etes  |   |                 |  |                                    |  |  |  |
|                   | ted<br>nsit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as  | a consequence of):  |   |                 |  |                                    |  |  |  |
| 0,                | cate be executed oblysician and the burial-transit   | Exar                | that initiated events<br>resulting in death) Last   | cDue to (or as   | a consequence of):  |   |                 |  |                                    |  |  |  |
| 8760,             | cate be<br>ohysici<br>the bu   | dical               | (   | d  |   |   |                 |  |                                    |  |  |  |
| P.O. Box 6        | The law requires that the death certifics ate has been signed by the attending phage 2 should be detached for use as It  | Physiclan/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown                          | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown             | 2 Fetal death 3   | Ectopic pregnanc Other (specify)                          | у               |  | 23d                                | . Date of deliver Month                  | very<br>Day Year                                   |  |
|                   | uires that<br>signed b<br>ld be deta   | by                  | Part II. Other significant conditions of  | ontributing to death b   | ut not resulting in the u                                 | nderlying cause giv                                       | ven in Part I.  |  | tobacco use                        |  | the cause of death?                                |  |
| of Vital Records, | e law requir<br>has been si<br>je 2 should l   | Completed           |   |  |   |   |                 | 24a. Wa                                    | s an 2                             | 4b. Were au                              | topsy findings available completion of cause of    |  |
| I Re              | The l  | Com                 |   |  |   |   |                 | perf                                       | ormed?<br>2⊠No                     | death?                                   | 2 No   |  |
| Vita              | Physician:<br>this certific<br>ral director,   | Be                  | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No   | Hospital:  |   | Ott   | ner.            | Death (Check only                          |                                    | 701 (0                                   |  |  |
| J of              | D 0 0  | n: To               | 27. Manner of Death   | 28a. Date of Inju  |   | IL SU DOA   | 4   Nursii      | ng Home 5 ☑ Res<br>28d. Describe           |                                    |  | city)  |  |
| Division          | Attending<br>r death.<br>ector: After<br>by the fune   | catlo               | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                              |  |   | M 1   | Yes 2 □ No      | 201 1                                      | <b>(0)</b>                         |  |  |  |
| Divi              | al or Al<br>s after o<br>l Directed in by  | Certification:      | 4 Homicide determined   | 28e. Place of Inj<br>building, et  | ury - At home, farm, st<br>c. (Specify)                   | eet, factory, office                                      |                 |  | (Street and N<br>Swn, State)       | umber or Hu                              | ıral Route Number,                                 |  |
|                   | To the Hospital or Attendin within 24 hours after death.  To the Funerel Director: Att completely filled in by the fun   | edical (            |   |  | of my knowledge, deat<br>f examination and/or in<br>ated. |   |                 |  |                                    |  |  |  |
|                   | To the within To the comp  | Me                  | 29b. Signature and title of certifier   | $\bigcirc$ $\triangle$   | 0 0   | 29c. Licens   |                 |  |                                    | igned (Month                             |  |  |
|                   |  |                     | ph  | 12/1/  | elevely 1   | 101   | 19294           |  | Apr                                | il 5,                                    | 2010   |  |
| 5                 | 3+1VA  |                     | 30. Name and address of person who  |  | leath (Item 23a) (Type;<br>11 Russe11                     |   | Gaith           | ersburg,                                   | Md. 20                             | 879                                      |  |  |
|                   | Sta<br>Registi   |                     | 31. Date filed (Month, Day, Year)   | 20 8   | as Signature  |   |                 |  |                                    |  |  |  |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |  |                  | For<br>State<br>Registrar   | State of M  | Maryland                       |                                 | rtmen<br>tificate     |                          |                             | nd Me                      |  | giene<br>Reg. No.        | 010                             | 12731  |
|---------------------|--|------------------|---|---|--------------------------------|---------------------------------|-----------------------|--------------------------|-----------------------------|----------------------------|--|--------------------------|---------------------------------|--|
| H                   | Physici  | an               | 1. Decedent's Name (First, Middle, Last)  | +-  |                                |                                 |                       |                          |                             |                            | Date of Dea                            | 1Day                     | 2010                            | 3. Time of Death                                   |
| Chairman            | /Medic   | al               | Marie Ellen LaPor  4a. Facility Name (If not institution, give s.   |   | r)                             |                                 | 4b. City,             | Town, or                 | Location of                 |                            | pril                                   |                          | County of Deat                  | 11:35 P M  |
|                     | /  | ei               | Julia Manor Nursin  |   |                                |                                 | Hage                  | ersto                    | wn                          |                            |  | Wa                       | shingt                          | on   |
|                     | Funeral<br>Director  |                  | 190-10-1003   | м <b>ЭДХ</b> F                                      | Age (In yrs. Ia<br>86          | est birthday)<br>Yrs.           | ff Under<br>Months    |                          | If Under 2<br>Hours         | Min. 3                     | Date of Birth<br>(Month, Da)<br>ULY 9, | 1923                     | 9. Birti<br>Peni                | hplace (State or Foreign<br>untry)<br>nsylvania    |
|                     | land land  |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City                      | , Town or Lo                    | cation                |                          |                             |                            |  |                          |                                 | 10d. Inside City Limits                            |
|                     | Mary<br>B-f eh   | tor              | Maryland Washingto  | on  |                                |                                 | Wil                   | liam                     | sport                       |                            |  |                          |                                 | 1 ☐ Yes 2 <b>XX</b> No                             |
|                     | or 28  | Funeral Director | 10e. Street and Number  |   |                                |                                 | 10f. Zip              |                          |                             |                            |  | 10g. Citize              | en of What Co                   | untry?   |
|                     | eath w   | erai             | 16639 Longstreet Dr   | 2. Was Deceder                                      | t Sver in L1 9                 | 3 12 V                          |                       | 2179.                    |                             | in? (Specif                | fy Yes or No-                          | 114                      | USA<br>4. Race - Ame            | rican Indian                                       |
| 326                 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ie marked other than "naturel", or Items 23a or 28e-f ehow aumatic event, the Medical Examinar must be notified at |                  | 1 Never Married 2 Married  3 Widowed 4 Divorced   | Armed Forces  1 Yes XI  If Yes, Give  Year or Dates | s?<br><b>3</b> No              | If                              | Yes, spec             | rfy Cubar                | Specify:                    | Puerto Rio                 | can, etc.)                             |                          | Black, White                    | e, etc.  |
| ς<br>Σ              | 72 hou   | eted             | 15. Decedent's Educ<br>(Specify only highest grade  | ation completed)                                    |                                | 16a. Deced                      | ent's Usua            | I Occupa                 | tion<br>uring most          | of working                 |  | 16b. Kind                | d of Business/                  | Industry   |
| 121                 | within ne.   | Completed by     | Elementary/Secondary (0-12)   | College (1-4o                                       | r 5+)                          | life. L                         | ewife                 | e retired)               | 9                           |                            |  | Т                        | Iome                            |  |
| 2                   | filed Hygie Dther I  | Be Co            | 17. Father's Name (First, Middle, Last)   |   |                                | HOUS                            | CWIIC                 | -                        | 18. Mother                  | 's Name (I                 | First, Middle,                         |                          |                                 |  |
| lan<br>I            | Wental<br>Wental<br>rrked  | To B             | Cyrle O   | 'Connell  | L                              |                                 |                       |                          | Mary                        | 7                          |  | But                      | ler                             |  |
| Maryland 21215-0036 | 2 sho  |                  | 19a. Informant's Name/Relationship (Typ   | •   |                                |                                 |                       |                          |                             |                            |  |                          | Town, State, 2                  |  |
| e,                  | 1 and<br>Health<br>em 27<br>ther t   |                  | Paul M. LaPorte -   | scepson   | 20b. Pl                        | 17812                           |                       |                          | E ROS                       | aCI<br>Dat                 | -                                      |                          | 1,MD 21<br>ation - City or      |  |
| JOE<br>L            | Pages<br>ent of<br>ht: If it<br>ry or o  |                  | 1 ☐ Burial XX Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  | moval from Stat                                     | e ce                           | metery, crem<br>erstow          | natory or or          | ther place               |                             | 1_14_:                     | 2010                                   |                          |                                 | Maryland   |
| Baltimore,          | permit. Pages 1 and 2 should be Oppartment of Health and Menia Importent: If item 27 is marked any injury or other traumatic as <u>once.</u>   |                  | 21. Signature of Fun-ral Separa Lorins  | 1   | nag                            |                                 |                       |                          |                             |                            |  |                          | Home,                           |  |
| <u> </u>            | 895 28   |                  | ling Al   | 34-   |                                |                                 |                       |                          |                             |                            |  |                          |                                 | t,MD 21795   |
|                     |  |                  | 23a. Part1. Enter the disease, or complic<br>shock, or heart failure. List only on                          | e cause on each                                     | line.                          |                                 |                       |                          | , such as c                 | cardiac or r               | espiratory ar                          | rest,                    |                                 | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician /Medical   |                  | Immediate Cause (Final disease or condition resulting in death)   | Due to (or a  | ty ( a                         | ence of):                       | 516                   | 4                        |                             |                            |  |                          |                                 |  |
|                     | Examiner   |                  |   | Due to (or a  | is a consequ                   | ianca of).                      | cuto                  | per                      | n. a                        |                            |  |                          |                                 |  |
| -                   | ס ≅  | iner             | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |   |                                |                                 |                       |                          |                             |                            |  |                          |                                 |  |
|                     | and<br>and<br>I-trans  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                                     |   | H P                            | e m v                           | • > A                 | . 5 ~                    |                             |                            |  |                          |                                 |  |
| 8760,               | icate be executed<br>physicien and<br>s the burial-transit   | dicai E          | 4   | 540 (5) (5)   | o a sonoqu                     | 31,00                           |                       |                          |                             |                            |  |                          |                                 |  |
| 9                   | law requires that the death certificate be executed<br>as been signed by the ettending physicien and<br>2 should be detached for use as the bunal-transit  | Medic            | VE SCHALLE  |   |                                |                                 | 20                    |                          |                             |                            |  |                          |                                 |  |
| ROX                 | leath certific<br>ettending p  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths?  | 3c. If yes, outcom<br>1 ☐ Live birth                | 2 Fetal                        | death 3                         | Ectopic pr            |                          |                             |                            |  | 23                       | 3d. Date of del                 | ivery<br>Day Year                                  |
|                     | the dev  | ysic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4 Pregnant<br>9 Unknown                             |                                | ath 5                           | Other (sp             | ecify)                   |                             |                            |  |                          | W.Grilli                        | Day  |
| ٠ <u>٠</u>          | uires that the de<br>i signed by the e<br>Id be detached f   | by Ph            | Part fl. Other significant conditions conf  | tributing to death                                  | but not resu                   | Iting in the ur                 | iderlying ca          | ause give                | n in Part I.                |                            | 23e. Did to                            | bacco us                 | e contribute to                 | the cause of death?                                |
| Vital Records,      | w requires<br>been sig<br>should b   | ed b             |   |   |                                |                                 |                       |                          |                             | _                          | 1 D Y                                  | ′es 2□                   | No 3□Pr                         | obably 4 dinknown                                  |
| ဗ                   | law re<br>nas be   | Completed        |   |   |                                |                                 |                       |                          |                             | _                          | 24a. Was<br>autop                      | sy                       | 24b. Were au                    | itopsy findings available completion of cause of   |
| r<br>ē              | sicien: The law<br>certificate has t<br>irector, page 2 s  |                  |   |   |                                |                                 |                       |                          |                             |                            |  | 3 No                     | death?                          | 2 No   |
| <b>X</b>            | sicier<br>certif<br>irecto   | o Be             | 25. Was case referred to medical examiner?  | ospital:  | tiont 2 Tis                    | ER/Outpatien                    |                       | Othe                     |                             |                            | Check only o                           |                          | CO.                             | -4.1   |
| on of               | ding Phy<br>h.<br>After this<br>funeral d  | $\vdash$         | 27. Mannar of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of In                                     |                                | 28b. Time of<br>Injury          |                       | 8c. Injury<br>Work       |                             | 28                         | d. Describe h                          |                          | Other (Specoccurred             | ciry)  |
| Division of         | after dea<br>after dea<br>Director<br>d in by the  | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of I<br>building,                        | njury - At ho<br>etc. (Specify | me, farm, stre                  | et, factory           | , office                 |                             | 28                         | f. Location (S<br>City or Tox          |                          | Number or Ru                    | ural Route Number,                                 |
|                     | To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director,                                     | Medical C        | 29a. Certifier 1 Certifying Phys (Check only one)   | ician: To the bes<br>er: On the basis<br>and manner | of examinati                   | vledge, death<br>ion and/or inv | occurred restigation, | at the tim<br>, in my op | e, date and<br>inion, deatl | d place, and<br>h occurred | d due to the a                         | cause(s) a<br>date and p | and manner as<br>place, and due | stated.<br>to the cause(s)                         |
|                     | To th<br>Withir<br>To th<br>comp   | Me               | 29b. Signature and title of certifier   | 1   |                                |                                 | 290                   | . License                |                             | ,                          | 1                                      |                          | signed (Mont                    |  |
|                     |  |                  | I faind mile  |   |                                |                                 |                       | DO                       | 603                         | 96                         |  | 4                        | 113/1                           | •  |
| ال                  | 4-6  |                  | 30. Name and address of person who con  | mpleted cause of                                    |                                | 23a) (Type,                     | Print)                | 112                      | - 6                         | 0                          | pal                                    | ~ !                      | +                               |  |
|                     | Sta  | te               | 31. Date filed (Month, Day Year)  | 32. Redis   | strar's Signat                 | ure                             |                       | (4                       | - 6                         | stor                       | N                                      | mn                       | 1,                              | 740  |
|                     | Registr  | _                | APR 4 % 20  | 110   | area.                          | A. A                            | arte                  |                          | 4                           |                            | 7                                      |                          |                                 |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April 3, Lechau Thi 2010 5:24 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🗆 M 2 屎 F May 22, 1929 219-29-7947 80 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Montgomery Germantown 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 IISA 13978 Lullaby Road 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 X No Specify: Completed 3 ₭ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Administration Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Truy Le Oanh T. Vo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or any 526 Rutgers Street, Rockville, MD 20850 Thong Tri Nguyen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State National Memorial Park 4/9/10 Falls Church, VA 22042 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility National Funeral Home 7482 Lee Highway, Falls Church, VA 22042 23a. Part 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Massive Intracerebral Hemorrhage Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Malignant Hypertension burial-transi and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 X No Month Year Pregnant at time of death 9 Unknown detached g Unknown P.O. | ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, cate has been siç ; page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate Yes 2 No 1 Yes 2 No in Hospital or Attending Physician: Tr n 24 hours after death. In Euneral Director: After this certificatiolated filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🙀 No ည 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending work' 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

G

Fisehatsion Mehari, MD 9901 Medical Center Drive, Rockville, MD 20850

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 09 2010 D0064478

04/04/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<sup>Day</sup> 201<sup>Yea</sup> April Robert Chester Lowry 2:30 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 42 2nd Street Lothian Anne Arundel Social Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** sex 1 X M 2 ☐ F Months Hours 3 /29 / 1 952 220-54-0767 Director 58 DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Anne Arundel Lothian 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2nd Street 42 20711 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 X Divorced Specify: White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) should be filed within 72.1 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government 12 Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Lowry, Sr. Mary Ida Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James Lowry, Jr./Brother 3604 King Dr., Dunkirk, MD20754 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
So. Mem'lGardens 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4/7/2010 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Raymond-Wood\_F.H., P.A. PO Box 430, Dunkirk, MD 00 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽πysiciaπ/ opho disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death g \ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in any contract of the cause of examination and/or inventioning in any contract. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and

31. Date filed (Month, Day, Year)

le of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USSAIN

APR 0 6 2010

22 32. Registra s Signature 2010

| 10-02664   | _             | _   | pe or Print i                     |                                       |                                  |  |   | •                                    | .egible            | ·                 |  |
|--|---------------|---|-----------------------------------|---------------------------------------|----------------------------------|--|---|--------------------------------------|--------------------|-------------------|--|
| Michael John M   |               | ire, Jr. S<br>1- For State  | tate of Maryl                     |                                       | rtment of<br><i>tificate of</i>  |  | and Menta                               | l Hygiene                            |                    | 201               | 0 1273   |
| Physici  |               | Registrar  1. Decedent's Name (First, Midd                              | lle,Last)                         | Cert                                  | incate or                        | Dealli   |   | 2. Date of D                         | Reg. No.           |                   | 3. Time of Death                                     |
| Medical Exami  |               | Michael John  | n McGuire                         | . Jr.                                 |                                  |  |   | Month<br>April 5,                    | Day<br>2010        | Year              | 1425 hrs   |
|  |               | 4a. Facility Name (if not instituti                                     |                                   |                                       | 4                                | b. City, Town,   | or Location of D                        |                                      |                    | County of Dea     | ath  |
|  |               | 4930 Crosby Road  |                                   |                                       |                                  | Rock Hall  |   |                                      |                    | ent               |  |
| Funeral  |               | 5. Social Security Number   | 6. Sex                            | 7. Age (In yrs. las                   | st birthday)                     | If Under 1 Y<br>Months D   |   | 3.6im                                |                    | Fore              | Birthplace (State or<br>eign                         |
| Director   |               | 177-44-2613   | 1 M 2 F                           | 59                                    | Yrs.                             |  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 5/17                                 | 7/1950             | 0 0               | Country) PA  |
| any  |               | Usual Residence of Decedent  10a, State  10b, County                    |                                   | 10c. City. 7                          | Fown or Location                 | on   |   |                                      |                    |                   | 10d. Inside City Limits                              |
| <b>≩</b>   | _             | MD Ke   | at                                | Ro                                    | ock Hal                          | 1  |   |                                      |                    |                   | 1 Yes 2 No   |
| arylan<br>8a-fs  | Director      | 10e. Street and Number  |                                   |                                       |                                  | 10f. Zip Code  | 9                                       |                                      | 10g. Citiz         | en of What Co     | ountry?  |
| r death with the Maryland<br>or items 23a or 28a-f show<br>must be notified at once.   | Ö             | 4930 Crosby   | Road                              |                                       |                                  | 2166   | 51                                      |                                      | 11:                | SA                |  |
| with ms 23   | uneral        | 11. Marital Status  | 12. Was De                        | cedent Ever in U.S                    |                                  | Decedent of  | Hispanic Origin?                        | (Specify Yes or<br>erto Rican, etc.) |                    |                   | erican Indian, Black,                                |
| r deatl  | Fun           |   | 1 X Yes                           | 2 No                                  |                                  |  |   | ierto Ricari, etc.)                  |                    | LIh               | ite  |
| rs after rall, niner   | ρ             | 3 Widowed 4 Di  | vorced If Yes, Give Ye or Dates:  | N/A                                   |                                  |  | No specify:<br>pation (Give kind        | l of work dono                       |                    | Specify: W11      |  |
| 2 hour   | ted           | Elementary/Secondary (0-12)   |                                   | 1-4 or 5+)                            |                                  |  | ife. DO NOT use                         |                                      | 100. K             | and of busines    | s/IIIddst[y  |
| D36<br>thin 7<br>re.<br>than   | ompleted      | 12  |                                   |                                       | Paint                            | er   |   |                                      | P                  | ainting           |  |
| 5-0036<br>iled within 7<br>Hygiene.<br>I other than  | ပ             | 17. Father's Name (First, Middle  | , Last)                           | •                                     |                                  |  | 18. Mother's N                          | ame (First, Middl                    | e, Maiden          | Surname)          | 7-2  |
| 2121<br>Muld be fil<br>Mental I<br>marked<br>c event,  | Be            | Michael J. M  |                                   | r.                                    |                                  |  |   | rine E.                              |                    |                   |  |
| D 2<br>should<br>and M<br>7 is ma  | ဥ             | 19a. Informant's Name/Relation  |                                   |                                       | 4                                |  |   | or Rural Route N                     |                    |                   | te, Zip Code)  |
| , MD<br>and 2 sho<br>cealth and<br>tem 27 is<br>traumati   |               | Adele M/ Finn   | egan/sist                         |                                       | lace of Disposi                  |  |   | lorsham,                             |                    | ocation - City    | or Town, State                                       |
| IOFE<br>ges 1<br>It of H<br>I: If i  |               | 1 Burial 2 X Crematio   |                                   | TOTAL STATE                           | ematory or oth                   | •  |   |                                      |                    |                   |  |
| Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 22a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.   |               | 4 Donation 5 Other S 21. Signature of Funeral Service                   |                                   | Che                                   | esapeak<br>122. N                |  |   | 4/7/10                               |                    |                   | .11e, MD   |
| Dept.  |               | Kick of G   | Kelfent                           | rein                                  | Fe                               | llows,<br>O Speei  | Helfenb<br>r Rd. Ch                     | ein & Ne<br>estertov                 | ewnam<br>yn, M     | Funera<br>D 21620 | l Home   |
| Physician  |               | 23a. Part I. Enter the disease, g<br>failure. List only one cause       |                                   | caused the death. (                   |                                  |  |   |                                      |                    |                   | Approximate Interval<br>Between Onset and            |
| /M di I<br>Examiner  |               | Immediate Cause (Final disease  |                                   | rotic Cardiova                        | scular Dise                      | ase  |   |                                      |                    |                   | Death  |
|  |               | or condition resulting in death)  | Due to (or as                     | a consequence of):                    | :                                |  |   |                                      |                    |                   |  |
|  | <u>ē</u>      | Sequentially list conditions, if any, leading to immediate              | Due to (or as                     | a consequence of):                    |                                  |  |   |                                      |                    |                   | +  |
|  | Examiner      | (Disease or injury that initiated                                       | C                                 | a consequence of):                    |                                  |  |   |                                      |                    |                   | 20   |
| uted<br>d<br>ansit   |               | events resulting in death) Last   | d.                                | a consequence ory.                    | •                                |  |   |                                      |                    |                   |  |
| tal Records, P.O. Box 68760, cian: The law requires that the death certificate be execut certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - tran  | an/Medical    | UNPENDED  | AMENDED                           |                                       |                                  |  |   |                                      |                    |                   |  |
| 760,<br>cate bo  | ě             | IF FEMALE:  |                                   | outcome of pregna                     | ancy                             |  |   |                                      | 23d                | . Date of delive  | ery  |
| Box 68760, death certificate be the attending physic of for use as the but of for use as the but of | cian          | 23b. Was decedent pregnant in t<br>past 12 months?                      | ' twe                             | birth<br>nant at time of deal         | th -                             | al death   | 3 Ectopic pre                           | egnancy                              |                    | Month             | Day Year   |
| 30x<br>death<br>ne atte  | hysic         | 1 Yes 2 No 9 Un   | known 9 Unkn                      |                                       | tri 5 ∐ Oth                      | er (Specify)   |   |                                      |                    |                   |  |
| P.O.  <br>es that the<br>igned by ti   | ₽             | Part II. Other significant condi  | tions contributing t              | to death but not res                  | sulting in the ur                | derlying cause   | e given in Part I.                      | 23e. Dio                             | _                  |                   | o the cause of death?                                |
| S, P<br>nires th<br>signe<br>d be d  | ed by         |   | <del></del>                       |                                       |                                  |  |   | -   -                                |                    |                   | obably 4 🗹 Unknown                                   |
| ord;<br>w requ<br>as beer<br>shoul   | Completed     |   |                                   | <del>_</del>                          |                                  |  |   |                                      | topsy              | prior to          | autopsy findings available<br>completion of cause of |
| Rec<br>The la<br>cate his  | E             |   |                                   |                                       |                                  |  |   |                                      | rformed?<br>s 2 No | death?            |  |
| Vital F<br>ysician:<br>his certifi<br>director,  | Be            | 25. Was case referred to medica examiner?                               | Hospital:                         |                                       |                                  |  | oce of Death (Che                       |                                      |                    |                   |  |
| of Vital Records, ng Physician: The law requir After this certificate has been s meral director, page 2 should t   | ၉             | 1 Yes 2 No<br>27. Manner of Death                                       | _   _ ' _ '                       |                                       | ER/Outpatient<br>28b. Time of In |  | Other Nu                                | rsing Home 5 28d. Describ            | <u> </u>           |                   | er: Scene  |
| Division of pipital or Attending Phours after death.  erral Director: After titled in by the funeral   | ë             | 1 ✓ Natural 5 Pen   | (Monti                            | h, Day,Year)                          | ZOD. TIM <del>O</del> OF III     | `  | yes 2 No                                | 200. Descrit                         | oe now injui       | y occurred        |  |
| Division tall or Attendir is after death.  | ertification: | 2 Accident Inve   | stigation 28e Plac                | ce of Injury - At hon                 | ne, farm, street                 |  |   | 28f. Location                        | n (Street ar       | nd Number or F    | Rural Route Number, City                             |
| Div  | Ē             |   | Id not be rmined (Specify)        | )                                     |                                  |  |   | or Town                              | , State)           |                   |  |
| Hosp<br>24 hos<br>Fune   | a<br>C        | 29a. Certifier 1 Certifying P   | hysician: To the be               | st of my knowledge                    | e, death occurr                  | ed at the time,  | date and place,                         | and due to the ca                    | ause(s) and        | I manner as sta   | ated.  |
| Division of Vital Records, P.O. Box 68760, vithin 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran   | Medical       | 2 🖳   | miner:On the basis<br>and manner: |                                       | d/or investigation               |  |   | ed at the time, da                   |                    |                   |  |
|  | Σ             | 29b. Signature and title of certifi                                     | 1/-                               | 700                                   |                                  |  | nse number                              |                                      |                    |                   | onth, Day, Year)                                     |
| 4  |               | Mun Br  | anell,11                          |                                       |                                  |  | C.M.E.                                  |                                      | April              | 6, 2010           |  |
| +  |               | <ol> <li>Name and address of person<br/>Melissa Brassell, MD</li> </ol> |                                   | se of death (Item 2<br>edical Examine | •                                | enn Street   | Baltimore, N                            | /ID 21201                            |                    |                   |  |
| ins<br>St  | ate           | 31. Date filed (Month, App par  |                                   | egitrar's Signature                   |                                  | Called   | 2.21                                    |                                      |                    |                   |  |
| Regist   | 100           | AFR   | O WILL                            | Baserie                               | S. Figure                        | State of the state |   |                                      |                    |                   |  |

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | Certificate of Death Reg. No 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death <sup>Day</sup>2010 Physician/ April Ronald Wayne Muhlen 2:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick 1088 Carlton Place, Apt. 8. Date of Birth (Month, Day, Year) April /, 1938 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 ☑ M 2 ☐ F Pennsylvania 71 Director 198-28-2396 Usual Residence of Decedent 10h County 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1088 Carlton Place, Apt. 1-A 21703 United States death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter/Drywall Finisher Construction traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ည Alfred Edmond Muhlen Gladys M. Beegle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy S. Muhlen / Son 12324 Delwood Ave., Hagerstown, 20a. Method of Disposition April 5 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖳 Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 201Ó Frederick, Maryland 21. Signature of June 1 Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 2 23a. Part 1. Ent to disease, or shock, or earl failure. List Immediate Carpe (Final disease or or of tition resulting in heath) opplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Physician second Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital 2 No ျှ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifie 29d, Date signed (Month, Day, Year) MD D0067442 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson Drive, Frederick, MD un Oh 46 B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR

Registrar

Bur sarah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1:25 AM McMillian Apr 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Paltimore Univ. of Maryland Shock Trauma BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. DEC. 2 <sup>Y</sup>1992 WASHINGTON, DC Director 579-23-2019 17 Usual Residence of Decedent ms 23a or 28a-f show must be notified at ould be filed within 72 hours after death with the Maryland id Mental Hygiene.
marked other than "natural", or items 23a or 28e-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Number 10g. Citizen of What Country? Funeral 11510 COLTS NECK DRIVE USA 20772 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married þ Specify BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE STUDENT 11TH Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental PImportant: If item 27 is marked o ပ CAROLYN D. MCMILLAN RAYMOND WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN CURRY/MOTHER 11510 COLTS NECK DRIVE UPPER MARLBORO, MARYLAND 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/12/2010 RESURRECTION CEME. CLINTON, MARYLAND 21. Signature of Fune al Service L 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ complication disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): burial-transi CERTIFICATION APPROVED BY MEDICAL resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy that the death Day 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? page 2 No 1 Yes æ 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 | No ျှ 1X Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at Hospital or Attending 1 Natural
2 Accident
3 Suicide (Month, Day, 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street factory, office 28f. Location (Street and Number or Rural R City or Town, State) 43/9 LDYA 4 Homicide determined building, etc. (Specify) COURT Upper Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier April 01, 2010 19197 5 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St. Baltimore, MD 21201 31. Date filed (Month, Day 32. Recentrar's S State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year April 6, 2010 Catherine Lucille Miller 6:05 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death County of Death Morningside House Ellicott City Howard Funeral Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Sept. 13, Yel 914 577-09-9167 95 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Direct 1 Yes 2 No Maryland Howard Dayton 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 4987 Morning Star Drive 21036 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Accounting Firm permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Katie Louise Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Raley/Daughter 4987 Morning Star Drive, Dayton, MD 21036 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 2010 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Septice Ligens Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Essential Hypertension Sequentially list conditions, if dry, leading to incredute cause. Enter Underlying Due to (or as a consequence of, Exami physiclan and s the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be nding t IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Day Year Pregnant at time of death signed by the a Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 Yes 2 No Yes 2 X No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Living Hospital 1 ☐ Yes 2 ☐ No Other: ရု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 A Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending injury s after death.

I Director: Aff
ed in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my in which a course at the time, date and place, and due to the cause(s) and manner stated. (Check To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D30641 April 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Ramesh Sabapathi, MD

09

31. Date filed (Month, Day, Year)

68760

Box

P.O.

Records,

of Vital

Division

32. Registrar's Signature

201-109 Back River Neck Road, Baltimore, MD 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>**2**010 Physician/ April 6, **Edward** Morgan ST. 8:38 P M Glenn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 10636 Bethel Road Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June th, Pay 1 32 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 1 M 2 D F **Funeral** Mary Tand Director 218-30-7880 Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Frederick Frederick Maryland 1 🗌 Yes 2 🗶 No 10f. Zip Code 21702 10g. Citizen of What Country? 10636 Bethel Road Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2X Married Completed by 1 Yes 2 No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) County Highway Dept. Foreman 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame May Baugher Nellie Morgan Charles Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 10636 Bethel Road, Frederick, MD 21702 Mary Morgan/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Union Chapel Cem 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Libertytown, MD 4/11/2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final 0551 Chronic Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Days to (or as a nonsequence of il ary, leading to immedia cause. Enter Underlying Cause (Disease or linjury Exami that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year ed by the a Yes 2 No 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ To the Hospital or Attending Physician; The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21707 31. Date filed (Month, Day 32. Registrar's Signature State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|   |   | _1              | For<br>State<br>Registrar   | Certificate of Death   | Reg. N  | 10.2010                  | 12739   |  |  |  |  |
|---|---|-----------------|---|--|---|--------------------------|---|--|--|--|--|
|   | Physicia  |                 | 1. Decedent's Name (First, Middle, Last)  |  |   | ay Year                  | 3. Time of Death                                  |  |  |  |  |
|   | /Medic  | al -            | Rachel Susan Michaels   |  |   | 02, 2010                 | 12:00 PM  |  |  |  |  |
|   | Examin  | er              | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of De  | eath 4  | c. County of Deat        | n   |  |  |  |  |
|   |   |                 | 10200 Settlement Road   | Eckhart  favi If Under 1 Year   If Under 24 F                              | rs   9 Date of Birth                                | Allegany                 | hplace (State or Foreign                          |  |  |  |  |
|   | uneral<br>Director  |                 | 5. Social Security Number 215-16-4457  6. Sex 1 □ M 2 1 F 7. Age (In yrs. last birthe   | Months Days Hours M  | lin. 8. Date of Birth (Month, Day, Yea December 03, | r) Co                    | ryland  |  |  |  |  |
| pu  | 3   | -               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of  | or Location  |   |                          | 10d. Inside City Limits                           |  |  |  |  |
| aryla   | sho   | 5               | 77 41   | ~  |   |                          | 1 □ Yes 2 No                                      |  |  |  |  |
| Je M  | Ba-f  | Director        | to Out of Market  | 10f. Zip Code  | 10g. (  | Citizen of What Co       | untry?  |  |  |  |  |
| vith t  | lo r  |                 | 10e. Street and Number 10200 Settlement Road  |  |   | S.A.                     |   |  |  |  |  |
| ath v   | s 23g   | eral            | 11 Marital Status 12. Was Decedent Ever in U.S.   | 21532-   |   | 14. Race - Ame           | rican Indian.                                     |  |  |  |  |
| er de   | tem E   | Funeral         | Armed Forces?   | 13. Was Decedent of Hispanic Origin?<br>If Yes, specify Cuban, Mexican, Pu | uerto Rican, etc.)                                  | Black, White             |   |  |  |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours aft       | o,  | by              | 1  Never Married 2  Married 1  Yes 2  No If Yes, Give 7  Year or Dates:   | 1 □Yes 2 No Specify:   |   | Specify: Wh              | vita  |  |  |  |  |
| 2 should be filed within 72 hours after death with the Maryland | inral   |                 | 15 Decedent's Education 168 F   | Decedent's Usual Occupation  | 16b.  | Kind of Business/        |   |  |  |  |  |
| 72 u  | "na   | Completed       | (Specify only highest grade completed)  | Give kind of work done during most of life. DO NOT use retired)            | working   |                          |   |  |  |  |  |
| withii  | than  | Ĕ               | Elementary/Secondary (0-12)   College (1-4or 5+)  | memaker  |   | memaker                  |   |  |  |  |  |
| pell  | Hygi<br>ther<br>int, the  |                 | 17. Father's Name (First, Middle, Last)   |  | Name (First, Middle, Maid                           | en Surname)              |   |  |  |  |  |
| be  | ed o  | Be              | Elijah M. Beeman  | Clara C  | lise  |                          |   |  |  |  |  |
| oulc  | d Me<br>nark<br>natic   | 유               |   | Mailing Address (Street and Number of                                      |   | y or Town, State,        | Zip Code)   |  |  |  |  |
| 2 s   | h an<br>7 is r<br>traur   |                 |   | 00 Settlement Road, N.W. I   |   | Maryland                 | 21532-  |  |  |  |  |
| and   | Healt   |                 |   |  | Date 20c  | Location - City or       |   |  |  |  |  |
| ges.  | or of   |                 | 174 Burial 2   ICremation 3   Hemoval from State  | Disposition (Name of crematory or other place)                             |   | b.aalaad                 | Marriand  |  |  |  |  |
| Pa  | tmen<br>tant:<br>jury   |                 | 4 □ Donation 5 □ Other (Specify) Sunse  |  | April 06, 2010 C                                    | umberland                | Maryland  |  |  |  |  |
| permit  | Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exp. (it or must be notified all once. |                 | 21. Signature of Euneral Service Licensee   | 22. Name and Address of Facility  Durst Funeral Home,                      | 57 Frost Ave., Fro                                  | stburg, MD               | 21532   |  |  |  |  |
| /   | ysician and bhysician and as the burial-transit   | edical Examiner | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  |   |                          |   |  |  |  |  |
| The law requires that the death certifica                       | y the attending ph<br>ched for use as th  | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 □ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)                               |   | 23d. Date of de<br>Month | elivery<br>Day Year                               |  |  |  |  |
| ires that   | signed b<br>I be deta   | þ               | Part II. Other significant conditions contributing to death but not resulting in Alzheimer 5 Disease  | ,  | to the cause of death?<br>Probably 4  Unknow        |                          |   |  |  |  |  |
|   | certificate has been signed by the attendin ector, page 2 should be detached for use a  | Completed       |   |  | 24a. Was an autopsy performer                       | prior to<br>death?       | autopsy findings available completion of cause of |  |  |  |  |
| Physician:  | certi   | a               | 25. Was case referred to medical examiner?  |  | Death (Check only one) ing Home 5 Residence         | 6 DOther (2)             | nocify)   |  |  |  |  |
| Phys  | this all dir  | P.              | 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Out 27, Manner of Death 28a. Date of Injury 28b. T  |  | 28d, Describe how                                   |                          | GUIY/   |  |  |  |  |
| ing   |   | io              | 1 Natural 5 Pending (Month, Day, Year) Ir   | njury Work?<br>M 1 □ Yes 2 □ No  |   | , ,                      |   |  |  |  |  |
| or Attending  | ter death<br>irector:<br>n by the   | Certification:  | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number City or Town, State)  |  |   |                          |   |  |  |  |  |
| Hospital  | 4 hours a<br>Funeral C  | Medical Ce      | 29a. Certifier  (Check only (Check only 2 Medical Examiner: On the basis of examination and   | d/or investigation, in my opinion, death                                   | occurred at the time, date                          | and place, and di        | Je to the cause(s)                                |  |  |  |  |
| the I   | within 2.   | led             | one) and manner stated.   | 20c License number   | 204   | . Date signed (Mo        | nth, Day, Year)                                   |  |  |  |  |
| 2   | Main Value  | 2               | 29b. Signature and title of certifier   | 290. License number  | 290   | 14/2/11                  | 3   |  |  |  |  |
|   | 3   |                 | Moundad   | H005600  | 5 0   | 7/2/1                    | 11016   |  |  |  |  |
| 1   | -,  |                 | 30. Name and address of person who completed cause of death (Item 23a) (  | Type, Print) Hillson EV  | mus-word  | NO. NO                   | xpr> usen c                                       |  |  |  |  |
|   |   |                 | 1   | F"   1   1   1   1   | 100100  |                          |   |  |  |  |  |
|   | nds   |                 | and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (17204 McMullan Hwy Siw)  31. Date filed Monte, Day, Yang (1888)  32. Registrar's signature   | cumberland n   | 10 21502  |                          |   |  |  |  |  |

10-02760 Norman Merrill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| orman Merriii   | 1- For State Certificate of Death Reg. No.   | 2010 1274   |
|---|--|---|
| Physician/  | Registrat  1 Decedent's Name (First_Middle Last) 2 Date of Death 2 Date of Death   | 3. Time of Death  |
| Medical Examiner  |  | 4c. County of Death   |
|   | 6206 Foster Street District Heights  | Prince George's   |
| Funeral   | Months Days Hours Min.   | M/DD/YYYY) 9. Birthplace (State or Foreign Country)                         |
| Director  | 578-04-7368 IMM 2 F 43 Yrs. 2-65-1   | 961 Country) V/-1   |
| any   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  | 10d. Inside City Limits   |
| . å l   | MO PRINCE GEORGE'S DISTRICT HEIGHTS  | 1 X Yes 2 No  |
| the Maryland tor 28a-f sh iffied at once  | 10e. Street and Number  10f. Zip Code  10g. C  20747   | itizen of What Country?   |
| - 2 -   |  | 14. Race - American Indian, Black,  |
| r death with or items 23  | 1 Never Married 2 Married Armed Forces? 1 Yes 2 No   | White, etc.   |
| s after ural", o  | 3 Wildowed 4 Divorced in 10, 10 September 2 In 10 September 160 Percentage 1 In 10 September 160 Percentage 1 In 160 Percentag | Specify: VV 111 C   |
| 5-0036 ed within 72 hour tygiene. other than "natu the. Medical Exan Completed  | during most of working life, DO NOT use retired)   | CONSTRUCTION  |
| 0036<br>within within energene  | 17 LABORER  18 Mother's Name (First, Middle, Maide   |   |
| 11215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", event, the Medical Examiner o Be Completed by I   |  |   |
| Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple  | 19h Mailing Address (Street and Number or Ru   Route Number  | City or Town, State, Zip Code)  |
| imore, MD 2 Pages I and 2 shoul nent of Health and N tant: If item 27 is n or other traumatic   | NORMAN E. MERRELL/FATHER 6206 FOSTER St. District Here 20a. Method of Disposition 20b. Place of Disposition Date 20c   | c. Location - City or Town, State   |
| Baltimore, MI<br>permit. Pages 1 and 2 s<br>Department of Health a<br>Important: If item 27<br>injury or other traum.   | 1 🔀 Burial 2 Cremation 3 🔀 Removal from State crematory or other place)  | HUNDMAN PA  |
| altin   | 4 Donation 5 Other Specify:  21 Signature of Funeral Service Licensee 22. Name and Address of Facility   | kg Clarence St  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s   | HUNDMAN PA 5545   |
| Physician Wedical   | Contact Cymphet Would of Hood  | Between Onset and Death   |
| Examiner  | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  |   |
| <u>.</u>  | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |   |
|   | Cause Enter Underlying Cause (Disease or injury that initiated   | ///   |
| uted Id ansit   | events resulting in death) Last Due to (or as a consequence or):  d.   |   |
| oe exectician an urial - tr   | UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy   |   |
| ox 68760, eath certificate be executed attending physician and for use as the burial - transit  | IF FEMALE: 23b. Was decedent pregnant in the 2   Sectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 2   Sectopic pregnancy 2   Sectopic pregnancy 3   Sectopic pregnancy 3   Sectopic pregnancy 3   Sectopic pregnancy 3   Sectopic pregnancy 4   Sectopic pregnancy 4   Sectopic pregnancy 5   Sectopic pregnancy 6   Sectopic pregnancy 7   Sectopic pregnancy 8   Sectopic pregnancy 9   Sectopic p   | 23d. Date of delivery<br>Month Day Year                                     |
| Box 687 death certific he attending p of for use as th  | past 12 months?  4 Pregnant at time of death 5 Other (Specify)   |   |
| D. BC:<br>the dea   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | co use contribute to the cause of death?                                    |
| res that the signed by be detac   |  | No 3 Probably 4 Unknown   |
| ords, w requir  | 24a. Was an autopsy performed 1  Yes 2   | 24b. Were autopsy findings available prior to completion of cause of death? |
| Recc<br>The lay<br>cate ha  | performed<br>1 ✓ Yes 2   | No 1 Yes 2 No   |
| Vital Recysician: The lability certificate lability director, page  | 25. Was case referred to medical 20. Place of Death (Check Only One)  M examiner?   Hospital:  | idence 6 🗸 Other: Scene   |
| of V ing Phys After thi Too   | 1 V Yes 2 No  28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how  | injury occurred   |
| ion<br>ttendin<br>leath.<br>for: A  | The state of Death 1   |   |
| Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been silled in by the funeral director, page 2 should be driftication: To Be Completed   | Ground not be   or Town, State   or Tow  | et and Number or Rural Route Number, City ) et, District Heights, MD        |
| Hospita<br>24 hour<br>Funers  |  | and manner as stated.   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transicolating Certification: To Be Completed by Physician/Medical E. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.   | place, and due to the cause(s)  Id. Date signed (Month, Day, Year)          |
| 2   |  | pril 8, 2010  |
| 5   | 30. Name and address of person who completed cause of death (Item 23a)   |   |
| MAS   | Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |   |
| Stat<br>Registra  | 1 C C C C C C C C C C C C C C C C C C C  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jaren Lee Myers 02:40 MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ST. JOSEPH MEDICAL CENTER BALTIMORE OW SON 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** <sup>Year)</sup> 2<u>010</u> 1 X M 2 D F Months Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Cecil Perryville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 525 Broad Street, Apt. B 21903 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) never worked never worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jason Edward Myers Kimberlee Knell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason E. Myers (father) 525 Broad St., Apt. B. Perryville, MD permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tr 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20h. Place of Disposition (Name of 20c. Location - City or Town, State West Chester Pennsylvania R.A. Ferris & Co.. 04/03/10 Inc: 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 24 hours after death. Funeral Director: After this certificate 2 🗌 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one Certificate: To 1 Tyes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

29b. Signature and title of certifier

ZHEN FAN

31. Date filed (Month, Day, Year)

OSLER DRIVE

m

7601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0060495

29d. Date signed (Month, Day, Year)

TOWSON MD. 21204

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** lorica 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 5465 Lyndale Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug • 18, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 □ XF Romania **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Predical Examinar must be notified at 1√Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Austria 5465 Lyndale Way 21703 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Economist Romanian Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ilie Niculescu Venerica Vanghelescu ပ္ 19a. Informant's Name/Relationship (Type. Print)
Mariana Nestianu / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5465 Lyndale Way, Frederick, Maryland 21703 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Izvorul Nou Date permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/10 4 ☐ Donation 5 ☐ Other (Specify) Bukarest, Romania 21. Signature of Funeral Serv ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the a □Yes 2 🗷 No 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been rector, page 2 shoult 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar te 200

Fralend

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive

32. Registrar's Signature

Johnson

46B Thomas

31. Date filed (Month, Day, Year)

|                                     | For<br>State<br>Registrar  |  | State of Mi   | aryiand /                                 | Departme<br><i>Certific</i>  |                                     |                                      | Mental H                                   | ygiene<br>Reg. No.                 | 2010                                  | 1271   |
|-------------------------------------|--|--|---|---|--|-------------------------------------|--------------------------------------|--|------------------------------------|---------------------------------------|--|
|                                     | Decedent's Name  | e (First, Middle, L  | ast)  |   |  |                                     |                                      | 2. Date of D                               | eath                               | L 0 1 0                               | 3. Time of Death   |
| ian<br>ical                         | Carro1   | 1 Andre  | w Perkins   |   |  |                                     |                                      | April                                      | 3, 20                              | 010 Year                              | 2100 P M   |
| ner                                 | , ,  | , 0  | ve street and number)   |   | 4b. C  | -                                   | Location of Dea                      |  | 4c.                                | County of Death                       |  |
|                                     |  | Cross H  |   | e (in vrs last h                          | irthday) If Un   | der 1 Year                          | ilver S                              | S 8 Date of B                              | irth                               | Montg                                 |  |
|                                     | 5. Social Security Number 6. Sex 1 Months Days Hours Min. Day Hours Min. Dec. 10, 1951 9. Birthplace (Ste Country) DC  Usual Residence of Decedent   |  |   |   |  |                                     |                                      |  |                                    | DC                                    |  |
| To Be Completed by Funeral Director | 10a. State   | 10c. City, Tov   |   |   |  |                                     |                                      |  | 10d. Inside City Limits            |                                       |  |
| Director                            | Maryland 10e. Street and Nu  |  |   |   |  |                                     | Suitlan                              | d  | 10a. Citi                          | izen of What Cour                     |  |
|                                     | 3414 Cur   | tic Driv   | e # 504   |   |  |                                     | 20756                                |  |                                    | nited Sta                             | •  |
| Funeral                             | 11. Marital Status   | CIO DIIV   | 12. Was Decedent<br>Armed Forces?                                       |   | 13. Was De   | ecedent of Hi                       |                                      | (Specify Yes or N                          |                                    | 14. Race - Americ                     | can Indian,  |
| þ                                   |  | 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: |   |   | S. 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes 2≅ No Specify: |                                     |                                      |  |                                    | Black, White, etc.  Specify: Black    |  |
| Completed                           | 15. Decedent's Education<br>(Specify only highest grade completed)   |  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working<br>life. DO NOT use retired)                    |                                     |                                      |  | 16b. Kind                          |                                       | dustry   |
| mo                                  | Elementary/Secondary (0-12) College (1-4or 5+)   |  |   |   | Bus Operator   |                                     |                                      |  |                                    | Private                               | e  |
| Be C                                | 17. Father's Name  | (First, Middle, Las  | it)   |   |  |                                     |                                      |  | ne (First, Middle, Maiden Surname) |                                       |  |
| 일                                   |  | Carro1   | 1 Andrew P  | erkins                                    | C  |                                     |                                      |  | Clara Daniels                      |                                       |  |
|                                     | 19a. Informant's Na  | ame/Relationship<br>a Perkins  |   |   | _  |                                     | and Numberor<br>Drive #              |  |                                    | or Town, State, Zip.d., Md.           | 20746  |
|                                     | 20a. Method of Disp  |  | s/ wire   | 20b. Place                                | of Disposition (   | Name of                             |                                      | Date                                       |                                    | ocation - City or To                  |  |
|                                     |  | ☐ Cremation 3 5 ☐ Other (Spec  | Removal from State  |   | Harmon<br>Tiarmon  | or <i>other pl</i> ac<br>ny<br>Park |                                      | ril 13,                                    | La                                 | ndover,                               | Marvland   |
|                                     | 21. Signature of Fu  | uneral Service Lice  | pece A  | Metho                                     | 22. Name   | and Addres                          | ss of Facility S                     |  | Tuner                              | al Home,                              |  |
|                                     | 23a. Part1. Enter t<br>shock, or bea<br>Immediate Cause<br>disease or condition<br>resulting in death)   | art failure. List o <b>nl</b><br>(Final                                  | mplications that caused yone cause on each line.  Anemia  Due to (or as | ne.                                       |  | node of dyin                        | ng, such as card                     | iac or respiratory                         | arrest,                            |                                       | Approximate<br>Interval Between<br>Onset and Death         |
| dical Examiner                      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Coagulopathy  Due to (or as a consequence of):  Liver Failure  Due to (or as a consequence of):  |  |   |   |  |                                     |                                      |  |                                    |                                       |  |
| Physician/Medica                    | IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown   | months?  | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant a<br>9 □ Unknown  | 2 Fetal deat                              | h 3 ⊟Ectopi<br>5 □ Other   | ic pregnancy<br>(specify)           | y                                    |  | -                                  | 23d. Date of deliv<br>Month           | rery<br>Day Year   |
| þ                                   | Part II. Other signi   | ificant conditions   | contributing to death b   | out not resulting                         | in the underlyir   | ng cause give                       | en in Part I.                        |  |                                    |                                       | the cause of death?  |
| Completed                           |  |  |   |   |  |                                     |                                      | 24a. Wa<br>au<br>pe<br>1□ Yes              | topsy<br>rformed?                  | prior to co                           | opsy findings available<br>ompletion of cause of<br>2 ☐ No |
| Be                                  | 25. Was case reference examiner?   | rred to medical  | Hospital:   |   |  | T 045                               |                                      | eath (Check only                           | y one)                             |                                       |  |
| ٩                                   | 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify   |  |   |   |  |                                     |                                      |  |                                    | ify)                                  |  |
| cation                              | 27. Manner of Death  1 Natural 5 Pending 2 Accident Accident Accident 28a. Date of Injury  (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 4 Nork?  1 Yes 2 No  28d. Describe how injury 4 Unique to the properties of th |  |   |   |  |                                     |                                      | rry occurred                               |                                    |                                       |  |
| Certification:                      | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could not determine  | d Zoe. Place of In  | jury - At home, f<br>tc. <i>(Specify)</i> | arm, street, fac   | ctory, office                       |                                      |  | (Street ar<br>Гомп, State          | nd Number or Rui<br>e)                | al Route Number,   |
| edical                              | 29a. Certifier<br>(Check only<br>one)  | 1 【X Certifying F<br>2 ☐ Medical Ex                                      | Physician: To the best<br>aminer: On the basis of<br>and manner st      | of examination a                          | ge, death occur<br>and/or investiga  | red at the tir                      | me, date and pla<br>opinion, death o | ace, and due to the<br>courred at the time | ne cause(s<br>ne, date an          | s) and manner as<br>nd place, and due | stated.<br>to the cause(s)                                 |
|                                     | 29b. Signature an  | title of certifier   | O   |   | $\sim$   | 29c. License                        |                                      |  |                                    | ate signed (Month                     |  |
| Me                                  | <b>**</b>  |  |   | , M                                       | 0  | D68                                 | 3126                                 |  | 0.7                                | 106/2                                 | -010   |
| Me                                  |  |  | o completed cause of d  | death (Item 23a)                          | ) (Type, Print)  |                                     |                                      | on, DC                                     | 2001                               |                                       | -010   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ April 8, Louis Anthony Pettey 8:01 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3406 Chiswick Court, #2D Montgomery Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct. | 17. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-26-7655 83 1 X M 2 🗆 F D.C Yrs Director 1926 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛂 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 3406 Chiswick Court, #2D 20906 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any hiury or other traumatic event, the M-dical Examiner mu once. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 X X/es If Yes, Give Year or Dates. 1 ☐ Yes 2 kkNo Specify: 3 Nidowed 4 □ Divorced Completed Specify: 1945-46 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Rail Transportation Elementary/Seconday (0-12) College (1-4 or 5+) Management Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James William Beauregard Pettey Elizabeth Lillian Marie Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10136 Crestberry Place, Bethesda, MD 20817 Louis S. Pettey/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State April 1 2010 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Fr 500 University Blvd. Funeral Home Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final anset and Death Physician/ Cerebral Hypoxia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Severe Intractable Anemia 6 mos. Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director name? Myeloid Metaplastic Syndrome 3 yrs. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ L 9 ☐ Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\raisebox{-4pt}{\buildrel \raisebox{-4pt}{$\Sigma$}}$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 😾 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 12xx Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d, Date signed (Month, Day, Year) April 8, 2010 D02338 who completed cause of death (Item 23a) (Type, Print)
Delaney, MD 3929 Ferrara Drive, Silver Spring, MD 20906 30. Name and address of person Richard P. 31. Date filed (Mg Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amended #19b perFH, ECHD RG 4 Certificate of Death

Beg. No.

Beg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Hazel M Putman April 3, 2010 9:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Rocky Ridge 14708 Motter Station Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** . Social Security Number 213–24–8237 Days Months Hours Sept 11, 1928 Maryland 81 **Director** Usual Residence of Decedent 28a-f show aţ 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified a Maryland Frederick Rocky Ridge 1 Tes 2 X No 10f. Zip Code **21778** 9 10g. Citizen of What Country? Examiner must be 14708 Motter Station Road 23a Funeral with USA items ? 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: "natural", Specify. Completed 3 Widowed 4 Divorced White Year or Dates other than "natur 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DONOT use retired)
CLETK 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Post Office 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Few Ethe 1 Shelton James 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Motter Station Road, Rocky Ridge, MD 21778 John Putman/ Son 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4/7/2010 Resthaven Mem Gards Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Juneral Service License 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, Md 21702 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dads on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Dije to for as a passequingo of cause. Enter Underlying Cause (Disease or linjury Prospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Yes director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 10 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) completed filled in by 4 - Homicide determined Medical 29a. Certifler 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ertifie

Registrar

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attending

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 April 2, Mary Pittas 9:50 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Golden LivingCenter Frederick 5. Social Security Number 8. Date of Birth
(Month, Day, Ye)
July 28, If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Year 1917 1 M 2 T F Days Hours New Jersey 139-14-2332 92 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Frederick Maryland Frederick 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 30 North Place 21701 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>چ</u> 1 ☐ Yes 2 ☒ No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 X Divorced Specify. "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of the control of the contr during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Insurance Agency Insurance Agent other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Athena Notara Stavros Karas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a George Pittas / Son 10016 Bent Cross Drive, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Aprilate 6 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once, Ь 2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fun 12 ervice Licen Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin mountain Hwy. Frederick, MD 2 MD 21701 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) emen Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Examiner Due to (or as a consequence of): transitthe Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last signed by the attending physician a be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 D M Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniurv 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 2170) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year

5

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** Jane F. Price March 26, 2010 10:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Care Center Frostburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F June 18, 1916 213-10-9748 93 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State ral", or Items 23a or 28a-f show Evanings must be notified at 1 Yes 2 ☐ No Director Frostburg Maryland Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4 Barnard Place Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 21532-Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: \$ 3 Widowed 4 □ Divorced White Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Ballistics Laboratory** Lab Technician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanette Rhoads James R. Fraser ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 21532-Linda Jane Taylor 18651 Cherry Lane, S.W. Frostburg 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Maryland Frostburg Memorial Park March 31, 2010 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 No 1 ☐ Yes 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death. leral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) MAR 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/  ${\stackrel{\mathsf{Month}}{\mathrm{APRIL}}}$ 4:30 PM PROCTOR HURLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S SPRINGDALE 3508 TYROL DRIVE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 XM 2 □ F Months Hours Min. MARYLAND 89 Director 579-18-7068 1921 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland Director PRINCE GEORGE'S SPRINGDALE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 3508 TYROL DRIVE 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE PHARMACEUTICAL MANAGER 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev ည MARY PROCTOR JOSEPH PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
211 CASTLETON PLACE UPPER MARLBORO, MARYLAND 20774 JONATHAN SCOTT/BROTHER-INLAW 20a. Method of Disposition

1 Description 2 Communication 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT • OLIVET CEMETERY 20c. Location - City or Town, State Date 3 Reproval from State WASHINGTON, DC 4/9/2010 4 ☐ Denation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Censes 22. Name and Address of Facility 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Medical requires that the death certificate be Box 68760 as 1 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day Pregnant at time of death 5 Other (specify) 2 No 9 🗌 Unknown 9 Unknown Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform this certificate 2X☐ No 2X No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Funeral Director; After thi sted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work?
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Yes 2 🗌 No Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide within 24 hours after City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 5. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CR 5 State

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MYRON MURDOCK M.D. 7235B HANOVER PARKWAY GREENBELT, MARYLAND

20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Apříl 2, Barbara Jeanne Quick 2010 1:35 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery . Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Pay, Year) 0V. 4, 1939 1 M 2 X F Hours 578-52-7929 70 Yrs Director Nov. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be 23a with Funeral 3042 M Street, South East 20019 United States items ? 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. African ō 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. "natural". 3 Widowed 4 Divorced Completed Year or Dates American item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within intent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor of Secondary Education 5+ Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Thomas Quick, Sr. Frances Latitia Chavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E. Quick/Sister 3042 M Street, S.E. Washington, D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date = 5 Burial 2 Cremation 3 Removal from State Important: If any injury or 04/09/2010 4 Donation 5 Other (Specify) Rock Creek Cemetery ! Washington, D.C. Stonal re of Funeral Service Licens 22. Name and Address of Facility McGuire Funeral Service, Inc. alerie 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death neumonice ₹hysician/ disease or condition resulting in death) Medical Due to ( r as a con lequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of and that initiated events Due to (or as a consequence of) resulting in death) Last bunial-1 the attending physician hed for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Other (specify) 1 Yes 2 Dunknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ₩ No 24a. Was an has autopsy this certificate Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 📈 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

Stock of the Funeral Director: After Natural 5 🗀 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ompleted filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie State

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

parke

32. Registrar's Signature

|                 |  |                  | For<br>State<br>Registrar   |  | iryiano             |                           | ertificate of   |  | Re   | g. No. 2010                                 | 12751   |
|-----------------|--|------------------|---|--|---------------------|---------------------------|---|--|--|---|---|
|                 | Physicia   | เท               | 1. Decedent's Name (First, Middle, Las<br>Jeannette Marion  |  |                     |                           |   |  | 2. Date of Death<br>Month                      | Day Year                                    | 3. Time of Death                                    |
|                 | /Medic   |                  | 4a. Facility Name (If not institution, giv  |  |                     |                           | 4b. City, Town, o   | r Location of Death                        | April :  | 13 2010<br>4c. County of Dea                | 11:50 A <sup>M</sup>                                |
|                 | , Examin   |                  | 13414 Paramount T   | errace   |                     |                           | Hager   | stown                                      |  | Washingto                                   | on County   |
| I               | Funeral  |                  | 5. Social Security Number 6. S<br>154-03-7377   | XZ   | (In yrs. la         | st birthday<br>Yrs.       |   | If Under 24 Hrs.<br>Hours Min,             | 8. Date of Birth<br>(Month, Day,<br>July 30,   | Year) 9. Bii                                | thplace (State or Foreign ountry)                   |
|                 | Director   |                  | Usual Residence of Decedent   |  | 88                  | 115.                      |   |  | July 30,                                       | 1921   Net                                  | v Jersey  |
|                 | yland<br>how   | _                | 10a. State 10b. County  |  | 10c. City,          | Town or I                 | _ocation  |  |  |   | 10d. Inside City Limits                             |
|                 | Ba-fs  | cto              | Maryland Washingt   | on County  | Hage                | rsto                      | wn  |  |  |   | 1 □Yes 2X No  |
|                 | ith th   | Dire             | 10e. Street and Number  |  |                     |                           | 10f. Zip Code   | •  | 10   | g. Citizen of What C                        | ountry?   |
|                 | sath v   | Funeral Director | 13414 Paramount T   | errace   | vor in II C         | 10                        | 2174:   |  | agify Vas or No.                               | U.S.A.<br>14. Race - Am                     | orioon Indian                                       |
| 2-0030          | be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Exercitive must be redified at   | þ                | 11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced   | Armed Forces?  1   |                     |                           | 3. Was Decedent of H<br>If Yes, specify Cuba<br>1 □Yes 2 🛣 No | Specify:                                   | Rican, etc.)                                   | Black, Whi                                  | hite  |
| 2-0             | 72 ho  | Completed        | 15. Decedent's Ec<br>(Specify only highest gra  | lucation<br>ade completed)                                     |                     | 16a. Dec                  | cedent's Usual Occup  | pation<br>during most of work              | ring 1   | 6b. Kind of Business                        | /Industry   |
| 7               | vithin   | m<br>du          | Elementary/Secondary (0-12)   | College (1-4or 5-  | +)                  | Rea <b>1</b>              | ve kind of work done . DO NOT use retired                     | d)   |  | D1 F-4-4                                    |   |
| 7 0             | Hygie<br>Hygie<br>ther i   | ပ္ပို            | 12 17. Father's Name (First, Middle, Last,  | )  |                     | Real                      | LOI   | 18. Mother's Nam                           | e (First, Middle, M.                           |   | ce Company  |
| /land           | Mental<br>Mental<br>arked o  | To Be            | Michael Warnetzk  |  |                     |                           |   | Perenia                                    | Rolco Wai                                      | rnetzke                                     |   |
| Mary            | 2 should be and Mental is marked craumatic ever  | _                | 19a. Informant's Name/Relationship (  | Type. Print)   |                     | 19b. Ma                   | iling Address (Street   | and Number or Ru                           | ral Route Number,                              | City or Town, State,                        | Zip Code)   |
|                 | and 2<br>lealth<br>m 27<br>her tr  |                  | Carl G. Renz-husb   | and  |                     |                           |   |  |  | town, MD 2                                  |   |
| baltimore,      | ges 1<br>nt of H<br>If Itel  |                  | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐  | Removal from State   | 20b. Pla            | nce of Disp<br>metery, cr | position (Name of<br>ematory or other place                   | ce)  |  | 0c. Location - City o                       |   |
|                 | it. Partmen<br>rtant:<br>njury   |                  | 4 □Donation 5 □Other (Specif  | fy)  | Res                 |                           |   |  |  |   | , Maryland  |
| מ               | permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic en once.  |                  | 21. Signature of Funeral Service Licer  | affaron  | Sur                 |                           |   |  | 0  | ,   | neral Home<br>, MD 21742                            |
|                 |  |                  | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only  | plications that caused one cause on each lin                   | the death.<br>e.    | Do not e                  | ^   | ng, such as cardiac                        | or respiratory arre                            | est,  | Approximate<br>Interval Between<br>Onset and Death  |
|                 | Physician<br>//Medical   |                  | Immediate Cause (Final disease or condition resulting in death)   | a. PARK  |                     |                           | lisease   |  |  |   | years   |
|                 | Examiner   |                  |   | Due to (or as a  | a conseque          | ence of):                 |   |  |  |   | /   |
| L               |  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b<br>Due to (or as a   | a cons <i>e</i> que | ence of):                 |   |  |  |   |   |
|                 | ecutec<br>ind<br>transil   | Examiner         | Cause (Disease or injury that initiated events  | c  |                     |                           |   |  |  |   |   |
| Š,              | be execian a   | E                | resulting in death) Last  | Due to (or as a  | a conseque          | ence of):                 |   |  |  |   |   |
| 08/0 <b>0</b> , | rtificate be executed<br>ng physician and<br>as the burial-transit   | ledical          | •   | d  |                     |                           |   |  |  |   |   |
| ZOX             | certif<br>nding<br>use as  | ∩/Me             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome   |                     |                           |   |  |  | 23d. Date of d                              | elivery   |
| ğ.              | w requires that the death cer<br>been signed by the attendin<br>should be detached for use   | Physician/M      | in the past 12 p onths? 1 □ Yes 2 ☑ No 9 □ Unknown  | 1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown               |                     |                           | 3 ☐ Ectopic pregnand<br>5 ☐ Other (specify) _                 | су   |  | Month                                       | Day Year  |
| ν,<br>T         | ss that<br>gned b  | by P             | Part II. Other significant conditions   | contributing to death bu                                       | ıt not resul        | ting in the               | underlying cause giv  | ven in Part I.                             | 23e. Did tob                                   | acco use contribute                         | to the cause of death?                              |
| ord             | equire<br>sen si<br>ould t   |                  |   |  |                     |                           |   |  | 1 □ Ye:  | s 2 □ No 3 □ I                              | Probably 4 Unknown                                  |
| Record          | g 22 3   | Completed        |   |  |                     |                           |   |  | 24a. Was an<br>autopsy<br>perform<br>1 □ Yes 2 | prior to death?                             | autopsy findings available o completion of cause of |
| VITAI           | ertifica<br>ctor, p  | Be C             | 25. Was case referred to medical examiner?  |  |                     |                           |   |  | th (Check only one                             |   |   |
| 5               | Physician:<br>this certific  | ဥ                | 1 Yes 2 No  | <del></del>  |                     | <u>.</u>                  | IEIIL 3 LI DOA  |  |  | nce 6 Other (Sp                             | ecify)  |
|                 | ding h.<br>After<br>funer  | tion             | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injui<br>(Month, Day                              | ry<br>v, Year)      | 28b. Time<br>Injury       | y Wor   | iry at<br>rk?<br>]Yes 2 □No                | 28d. Describe hor                              | w injury occurred                           |   |
| DIVISION        | Attending<br>ir death.<br>ector: After<br>by the fune  | fical            | 3 Suicide 6 Could not b   | e 290 Place of Init  | ıry - At hor        | ne, farm,                 | street, factory, office                                       | 1162 2 110                                 | 28f. Location (Str                             | reet and Number or I                        | Rural Route Number.                                 |
| $\leq$          | al or safter   | Certification:   | 4 ☐ Homicide determined   | building, etc  | :."(Specify,        |                           |   |  | City or Town                                   | , State)                                    |   |
|                 | To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | Medical (        | 29a. Certifier   1   Certifying PI   (Check only one)   2   Medical Example   | hysician: To the best of miner: On the basis of and manner sta | <i>e</i> xaminati   | rledge, de<br>on and/or   | eath occurred at the t<br>investigation, in my                | ime, date and place<br>opinion, death occu | e, and due to the ca<br>arred at the time, da  | ause(s) and manner<br>ate and place, and di | as stated.<br>ue to the cause(s)                    |
| _               | To the withing the complete co | ž                | 29b. Signature and title of terrifier   | 1 1  | ۸.                  | 1                         | 29c. Licens   | -  | 29   | 9d. Date signed (Mor                        | nth, Day, Year)                                     |
|                 |  |                  | My My   | 1 no ("  | Jelus               | ~/                        | D5  | 6180                                       | 1  | Spart /                                     | 1, 2010   |
| 51              | 17   |                  | 30. Name any three's of person who  | fz 11110   | Med                 | lica                      | e, Print) ( Campu   | is Rd H                                    | lagersto                                       | wn, MD                                      | 21742   |
|                 | Sta<br>Registr   |                  | 31. Date filed (Mohth, Day, Year)   | 32. Registra   | ar's Signati        | J. A                      | bare  |  | J  |   |   |
| _               |  |                  |   |  |                     |                           |   |  |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day FORREST WILLIE ROBINSON 2010 Medical PRT 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL PRINCE GEORGE'S LANHAM Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours Min. FEB 13 212-54-3744 60 WASHINGTON, DC ິ່1950 Director Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 √2 Yes 2 □ No PRINCE GEORGE'S CAPITOL HEIGHTS 10e Street and Number ö 10f. Zip Code 10a, Citizen of What Country? Funeral items 23a 6221 LEE PLACE 20743 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, the Medical Examiner ò þ 1 X Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH BUTCHER PRIVATE injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ည ROLAND ROBINSON MARY **JENKINS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 7012 SCOTCH DRIVE LAUREL, MARYLAND 20707 MARY ROBINSON/MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗍 Removal from State RIVERDALE CREMATORY 4/9/2010 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, CARDIOPULMONARY COLLAPSE disease or condition Medical resulting in death) Due to (or as a consequence of): Examine RENAL CELL CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): the burial-transit Cause (Disease or linjury that initiated events END STAGE RENAL DISEASE and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No detached for 5 Other (specify) the g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be PARTIAL SMALL BOWEL OBSTRUCTION Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 🏝 No Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: 2**X** No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be ģ Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 4DRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIMA CALAF M.D. P. O. BOX 297 GREENBELT, MARYLAND

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 9 2010

32. Registrar's Signature

Please Type or Print in Black Indelible lok Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010<sup>ear</sup> APRIL Day Physician/ 4:22 A ROBERTS Μ. RIITH Medical 4c. County of Death Rita's Assisted Living facility 1501—BROOKE-ROAD 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CAPITOL HEIGHTS g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth ocial Security Number 7. Age (In yrs. last birthday, Month, Day, **Funeral** Days VIRGINIA 1 □ M 2 🗓 F Months Hours 1933 AUG. 579-46-2956 Director 76 Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10a. State 10b. County with the Maryland must be notified at Director X☐ Yes 2 ☐ No 28a-f PRINCE GEORGE'S CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 23a 20743 401 71st AVENUE death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene.
Important: If item 27 is marked other the any injury or other traumary. Examiner Armed Forces?
1 ☐ Yes 2 🛣 No Black White, et 1 Never Married 2X Married BLACK þ 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE COOK 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ MARY WATKINS SAMUEL FITZGERALD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 71st AVENUE CAPITOL HEIGHTS, MARYLAND 20743 JAMES\_L. ROBERTS/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 2 Cremation 3 Removal from State FT. LÍNCOLN CEMETERY 4/09/2010 BRENTWOOD, MARYLAND 4 Donation 5 Dther (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Signature of Fune Service Liverises 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events DIABETES physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be HYPERTENSION キゼロールントールの Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) a 🗆 Hinknown the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The law has autopsy performed 2X No 2 X No 1 Tes certificate Yes 26. Place of Death (Check only one) 25. Was case referred to medica Certificate: To Be Assistant Living examiner?
1 Yes Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death After 1 (Month, Day, Year) work?
1 Yes 2 No injury X Natural 5 Pending М the f Accident Investigation after death 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital of 24 hours a Funeral D Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of contific 29d. Date signed (Month, Day, Year)

CA 10

Registrar

DHMH 17 Rev 7/2009

racks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Hill M.D.

31. Date filed (Month, Day, Year)

APR 0 9 2010

D53235

13635 Baltimore Avenue Laurel, Maryland

APRIL 6, 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                | 1- State of Maryland State of Maryland Registra Amend#8. PerInfrmnt. PGC4-16   |                              | artment of Health and I<br>r <i>tificate of Death</i>  |   | giene<br>Reg. No. 201                                     | 12754  |
|--|----------------|--|------------------------------|--|---|---|--|
| Dhusi  | -:             | Decedent's Name (First, Middle, Last)  |                              |  | 2. Date of Dea                          |   | 3. Time of Death   |
| Physi<br>∞ /Med  |                | OSWALD VAUGHAN   |                              | ROBERTS  | APRIL                                   | 4 2010  | 8:03 A M   |
| Exam   | iner           | 4a. Facility Name (If not institution, give street and number) PRINCE GEORGE S HOSPITAL  |                              | 4b. City, Town, or Location of Death CHEVERLY  |   | 4c. County of De  | _  |
| Funera   | al             | 5. Social Security Number 6. Sex 7. Age (In yrs. las   | st birthday)                 | If Under 1 Year   If Under 24 Hrs.   | 8. Date of Birt                         |   | rthplace (State or Foreign                                   |
| Directo  |                | 218-63-5445 1 <sup>™ 2□ F</sup> 21   | Yrs.                         | Months Days Hours Min.   | 8. Date of Birt<br>(Month, Day<br>APRIL | 5 1988 EN   | GLAND  |
| and  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City,   | Town or Lo                   | cation   |   |   | 10d. Inside City Limits                                      |
| Maryl<br>-f sho  | ţo             |  | YATTSV                       |  |   |   | 1X Yes 2 □ No  |
| h the  | Director       | 10e. Street and Number   | INIIDV                       | 10f. Zip Code  |   | 10g. Citizen of What C                                    | ountry?  |
| or death with the Marylar<br>tems 23a or 28a-f show  |                | 5016 60TH AVENUE   |                              | 20781  |   | USA   |  |
|  | by Funeral     | 11. Marital Status  1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: |                              | Was Decedent of Hispanic Origin? (S <sub>I</sub><br>if Yes, specify Cuban, Mexican, Puerto<br>1 □Yes 2 X No Specify: | pecify Yes or No-<br>Pican, etc.)       |   |  |
| 215-0036<br>ithin 72 hours aff<br>nen "natural", or  | eted           | 15. Decedent's Education (Specify only highest grade completed)  | 16a. Deced                   | dent's Usual Occupation  | vina .                                  | 16b. Kind of Business                                     | s/Industry   |
| ithin 7  | Completed      | Elementary/Secondary (0-12) College (1-4or 5+)   |                              | kind of work done during most of work<br>DO NOT use retired)   | ang                                     |   |  |
| d 27<br>filed w<br>Hygie<br>other ti   | Ö              | 17. Father's Name (First, Middle, Last)  | SUPP                         | PORT MANAGER   | o (First Middle                         | PRIVATE  Maiden Surname)                                  |  |
| e de la la la la la la la la la la la la la  | To Be          | LENNOX S. ROBERTS  |                              |  | RAEPER                                  | walden damamey  |  |
| aryla<br>should<br>and Mer<br>s marke<br>umatic  | ٦              | 19a. Informant's Name/Relationship (Type. Print)   |                              | ng Address (Street and Number or Ru  |   |   |  |
|  |                | PAULA RAEPER ROBERTS/MOTHER  | 5016                         | 60TH AVENUE HYAT   | TSVILLE                                 | ,MARYLAND   | 20781  |
| 0 80 = 5   |                |  |                              | natory or other place)   | Date                                    | 20c. Location - City of                                   | · –  |
| timen ritmen rit |                | 4 □ Donation 5 □ Other (Specify) GATE  |                              | IEAVEN CEMETERY 4/   |   | SILVER SP<br>NKINS FUNE                                   | RING, MARYLAND   |
| Baltim permit. Pag Department Important: I   |                | 21 Signature of Juneral Service Licensee   |                              | 2. Name and Address of Facility 2474 LANDOVER ROAL   |   |   |  |
|  |                | 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.                                 |                              |  |   |   | Approximate<br>Interval Between                              |
| Physiciar  | 1              | Immediate Cause (Final disease or condition  | TORSO                        | TRAIMA   |   |   | Onset and Death  |
| /Medica  | •              | resulting in death)  Due to (or as a conseque  | ence of):                    | E ACCIDENT   |   | 1 pue   |  |
| Lamino   | ш.             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   |                              | E ACCIDENT   | Ret                                     | 2/40 597  | 7  |
| uted<br>d<br>ansit   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events   |                              | 1 Card   | w/Ja                                    | Hospe   |  |
| e exection and an   | Exa            | resulting in death) Last Due to (or as a conseque  | ence of):                    | E ACCIDENT   |   |   |  |
| <b>68 / 60,</b> tificate be executed g physician and as the burial-transit   | edical         | d  |                              |  |   |   |  |
| BOX be at the certification of |                | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance  |                              | _  |   | 23d. Date of d  | elivery  |
| t the death<br>ty the atte<br>by the atte  | Physician/M    | in the past 12 months?  1   Yes 2   No 9   Unknown   |                              | Ectopic pregnancy Other (specify)  |   | Month   | Day Year   |
| S, Fes that igned be det   | by P           | Part II. Other significant conditions contributing to death but not result   | ting in the ur               | nderlying cause given in Part I.   |   |   | to the cause of death?                                       |
| ord<br>requir<br>een s   | ted            |  |                              |  | 1 🗆 \                                   | ∕es 2⊠ No 3∐ I  | Probably 4 ☐ Unknown   |
| LIVISION OT VITAI HECOTAS, P.O. BOX to the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as  | Completed      |  |                              |  | 24a. Was<br>autop<br>perfo<br>1 □ Yes   | osy prior to<br>rmed? death?                              | autopsy findings available<br>completion of cause of<br>es 2 |
| VITAL sician: 7 certifical   | Be             | 25. Was case referred to medical examiner?  1 □ Yes 2 □ No  Hospital: 1 □ Inpatient 2 □ Fi   |                              | 26. Place of Dea   |   |   |  |
| UIVISION OT I or Attending Phy. after death. Director: After this d in by the funeral di   | on: To         | 27. Manner of Death 1 Natural 5 Pending Inpatient 2 E  | 28b. Time of                 | 28c. Injury at   | 28d. Describe h                         | dence 6 □ Other (Sp<br>now injury occurred —<br>VENICLE F | briver   |
| ISIC<br>Nttend<br>death<br>death<br>ctor: ,  | Certification: | 2 ☐Accident investigation ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  | o 2 3                        |  |   |   |  |
| alor/<br>safter<br>i Dire  | erti           | 3 Suicide 6 Gooda Not be 4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)  | ET                           | ,,,  | PARKWA                                  | Street and Number or I<br>vn, State)<br>Y∽NR NASA         | GREENBELT MD.  |
| e Hospit<br>24 houn<br>e Funera<br>letely fille  | edical (       | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowl on the basis of examination and manner stated.                                    | ledge, death<br>on and/or in | n occurred at the time, date and place<br>vestigation, in my opinion, death occu                                     | , and due to the<br>rred at the time,   | cause(s) and manner<br>date and place, and d              | as stated.<br>ue to the cause(s)                             |
| To th<br>withir<br>To the  | Me             | 29b. Signature and title of certifier  |                              | 29c. License number  |   | 29d. Date signed (Mo                                      | nth, Day, Year)  |
|  |                | and ky   |                              | D40386   |   | 4/4   | 12010  |
| N5   |                | 30. Name and address of person who completed cause of death (Item 2  | 23a) (Type, HOSP)            | ITAL DR. CHE   | EVERLY,                                 | MS 20   | 785  |
| S<br>Regis   | tate<br>trar   | 31. Date filed (Month, Day, Year)  APR 0 9 2010  April 32. Registrar's Signature   | acked                        | •  | /                                       |   |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 2010 OK Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE mo Social Security Number 6 Se 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days Min. (Month, Day, Year, PRIL 4. Months Hours Director 184-64-0608 26 Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5715 43RD AVENUE #3 20781 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married 1 Yes Completed by Maryland 21215-0036 1 Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH MAIL CLERK GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LANTERI RIVERSON SARAH LOWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3603 55TH AVENUE #7 HYATTSVILLE, MARYLAND 20784 SARAH LOWMAN/MOTHER Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 4 ☐ Bonetion 5 ☐ Other (Specify) 4/6/2010 RIVERDALE, MARYLAND uneral Service Licen, ee Signature of 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Hepatitis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Sail Due to (or as a consequence of Exami burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be tection Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy ó in the past 12 months? Month Year 5 Other (specify) detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à be Division of Vital Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 1 ☐ Yes 2 🔀 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 2 X No 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifie 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

UR 3

State Registrar Minghan Leo

APR 0 9 2010

31. Date filed (Month, Day,

M.D

32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15au

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 6, 2010 2:37 PM Elizabeth A. Rivers Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Montgomery Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign last birthday 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 925 1 M 2 1 F 85 Hours 578-24-3068 Pennsylvania Yrs Jan. Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. 10d. Inside City Limits Director Maryland Montgomery Rockville 1 ☐ Yes 2 🎦 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 294 Lynch Street 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S 14. Race - American Indian Armed Forces by 1 Never Married 2 Married 1 Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working marked other than Elementary/Seconday (0-12) College (1-4 or 5+ 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed ment of Health and Mental Hy tant: If item 27 is marked ott 18. Mother's Name (First, Middle, Maiden Surname) Anne C. Hanley John E. Fuchs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16509 Cavalry Drive, Rockville, Maryland 20853 Gary M. Rivers (Son) permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cametery, crematory or other place)
Gate of Heaven
Cemetery April Pate 12, 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Silver Spring, Maryland 2010 21. Signature of Fune Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877 M00689 Ranth Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between nset and Death Week Immediate Cause (Final Physician Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respiratory Insufficiency 1 week Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Unicerying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Emphysema 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 x No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificates 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 10 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R113971 April 7, 2010 0

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause

09 2010

31. Date filed (Month, Day, Year)

APR

nos

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Verdum Redman, Sr. Craig М 2010 2016 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/27/195 Birthplace (State or Foreign Country) **Funeral** 1 🖁 M 2 🗆 Days Hours Min. Director 233-84-1089 58 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits LaVale 1 Yes 2 No Allegany Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 1138 Braddock Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 X Married Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", 1 ☐ Yes 2 🔀 No Specify Yes. Give Specify: Completed 3 Widowed 4 Divorced Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Transportation</u> Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia ೭ Redman Elizabeth Kane William James and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1138 Braddock Road, LaVale, MD 21502 Jody L. Redman / Wife Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mary's Cemetery 04/10/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Si viature of Funeral Ser 21502 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Carcinoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Due to (or as a consequence of) sician and burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician thed for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has page 2 autopsy perform this certificate 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After (Month, Day, Year) 1 Natural injury 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MA 000 8216 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbrook Rd

DHMH 17 Rev 7/2009

State Registrar

even

Smith MD

32. Registrar's Signature

12501

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| George Rice, III  |                | 1- For State   | State of Mary   | land / L                      | Department<br>Certificate          |   | d Mental                |   | 2011<br>eg. No.                                | 0 1275   |
|---|----------------|--|---|-------------------------------|------------------------------------|---|-------------------------|---|--|--|
| Physicia  |                | Registrar<br>1. Decedent's Name (First, M  | Middle,Last)  |                               |                                    |   |                         | 2. Date of Dea<br>Month                 |  | 3. Time of Death                                 |
| Medical Examir  | ıer            | George R   |   |                               |                                    |   | March 30                |   |  | 1055 hrs   |
|   |                | 4a. Facility Name (if not insti<br>4720 23rd parkway   |   | number)                       |                                    | 4b. City, Town, or<br>Temple Hill           |                         | eath                                    | 4c. County of Death                            |  |
| Funeral   |                | 5. Social Security Number  | 6. Sex  | 7. Age (I                     | n yrs. last birthday)              |   |                         |   | th(MM/DD/YYYY) 9. Bir<br>Forei                 | an   |
| Director  |                | 577–62–5389  | 1 <b>X</b> M 2 F  |                               | 63                                 | Months Day                                  | s Hours N               | <sup>vlin.</sup> 04/19                  | /1946 c  | ountry) DC                                       |
| any   | F              | Usual Residence of Deceder<br>10a. State 10b. Cou  |   | 110                           | c. City, Town or Loc               | ation                                       |                         |   |  | 10d. Inside City Limits                          |
| <u> </u>  |                |  | .nce George   |                               | Temple Hi                          |   |                         |   |  | 1 Yes 2 No                                       |
| Maryland<br>28a-f show<br>d at once.  | 횽              | 10e. Street and Number   | 1100 000190   |                               | -0                                 | 10f. Zip Code                               |                         | 1                                       | 0g. Citizen of What Cou                        | intry?   |
| with the Maryland<br>ns 23a or 28a-f sho<br>be notified at once   | Director       | 4720 23rd Pa   | rkwav #3  |                               |                                    | 207   | 48                      |   | USA  |  |
| n with  | Funeral        | 11. Marital Status   | 12. Was D   | ecedent Eve<br>Forces?        |                                    | Was Decedent of His<br>f Yes, specify Cubar |                         |   | - 14. Race - Amer<br>White, etc.               | rican Indian, Black,                             |
| or ite  | ᇤ              | 1 Never Married 2  | 1 X Yes   | 2                             | No                                 | _   |                         | , | specify: Bla                                   | ck   |
| ırs afte<br>ural",  | à              | 3 Widowed 4 15. Decedent's Education (   | Divorced If Yes, Give Y<br>or Dates:<br>Specify only highest gr |                               |                                    | Yes 2xx No                                  |                         | of work done                            | 16b. Kind of Business/                         |  |
| 5-0036<br>led within 72 hours after<br>Hygiene.<br>other than "natural",<br>the Medical Examine   | Completed      | Elementary/Secondary (0-   | -12) College  | (1-4 or 5+)                   |                                    | most of working life                        | . DO NOT use            | retired)                                | Government                                     |  |
| onthin ene.   | g              |  | 4   |                               | Su                                 | pervisor                                    |                         |   |  |  |
|   | Be Co          | 17. Father's Name (First, Mic  |   |                               |                                    |   |                         | ame (First, Middle, I<br>et Anders      |  |  |
| 2 5 5 E 5   |                | George A. R  |   |                               | 19b. Mai                           |   |                         |   | nber, City or Town, State                      | a, Zip Code)                                     |
| MD and 2 sho alth and m 27 is sumati  |                | Margaret L. R  | Rice/ Mothe   | r                             |                                    |   |                         |   | n, DC 20020                                    |  |
| U 4 2 2 2 1   |                | 20a. Method of Disposition  1 Rurial 2 Crema   | ation 3 Removal   | from State                    | 20b. Place of Disp<br>crematory or | osition (Name of ce other place)            | - "                     | Date                                    | 20c. Location - City or                        |  |
| Baltimore,<br>permit. Pages I an<br>Department of Hes<br>Important: If ite  |                | 4 Donation 5 Othe  | er Specify:   |                               |                                    | coln Ceme                                   |                         | 1/8/2010                                | Brentwood                                      | d, MD  |
| Baltimore permit. Pages 1 Department of I Important: If injury or other   | ļ              | 21. Signature of Funeral Ser   | vice Licensee   |                               |                                    | . Name and Addres<br>Ri⇒nchi 81             | -                       | ır ST NW                                | Wash DC 2                                      | 20011  |
| Physician   | +              | Bianchi 814 Upshur ST NW Wash., DC 2  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart |   |                               |                                    |   |                         |   |  | Approximate Interval<br>Between Onset and        |
| Examiner  |                | failure. List only one ca<br>Immediate Cause (Final dise   | 11 - 4  | sive Athe                     | erosclerotic Ca                    | diovascular Di                              | sease                   |   |  | Death  |
| Lxammer   |                | or condition resulting in deat   | th) Due to (or as   | a consequ                     | ence of):                          |   |                         |   |  |  |
|   | 힐              | Sequentially list conditions, if any, leading to immediate   | Due to (or as   | a consequ                     | ence of):                          |   |                         |   |  | <del>                                     </del> |
|   | Examiner       | cause. Enter Underlying Ca<br>(Disease or injury that initiate<br>events resulting in death) Li  | ed C.   | a consequ                     | ence of):                          |   |                         |   |  |  |
| cuted<br>md<br>transit  | Ĭ              | events resulting in death). Li   | d   |                               |                                    |   | -                       |   |  |  |
| iO,  e be executed ysician and burial - transit   | edical         | UNPENDED   | AMENDEC   |                               |                                    |   |                         |   |  |  |
| 3760<br>ificate<br>ig phys<br>s the b   |                | IF FEMALE:<br>23b. Was decedent pregnant   |   | s, outcome o                  | of pregnancy                       | Fetal death 3                               | Ectopic pre             | gnancy                                  | 23d. Date of deliver<br>Month                  | y<br>Day Year                                    |
| Box 6876: death certificate the attending phy   | sician/N       | past 12 months?  | 4 Pre   | gnant at tim                  |                                    | Other (Specify)                             |                         |   | 1  |  |
| . BC<br>the dea   | Phys           | Part II. Other significant co  | 9 011   | nown                          | ut not resulting in th             | e underlying cause                          | niven in Part I.        | 23e. Did to                             | obacco use contribute to                       | the cause of death?                              |
| P.O.  |                | Diabetes Mellitus  |   |                               |                                    |   |                         | 1Ye                                     | s 2 No 3 Pro                                   | bably 4 🗸 Unknown                                |
| Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the finneral director, page 2 should the finneral director, page 2 should the finneral director, page 2 should the finneral director, page 2 should the finneral director, page 2 should the finneral director, page 2 should the finneral director, page 2 should the finneral director, page 2 should the finneral director, page 2 should the finneral director. | Completed by   |  |   |                               |                                    |   |                         | 24a. Was                                |  | utopsy findings available completion of cause of |
| ecol<br>ne law<br>te has  | gu             |  |   |                               |                                    |   |                         | perfo                                   | rmed? death?                                   | es 2 No  |
| tal Recision: The certificate ector, page   | a              | 25. Was case referred to me  |   |                               |                                    | 26.Plac                                     | e of Death (Che         |   |  |  |
| Vit;  | To B           | examiner? 1 Yes 2 No   | Hospital: 1   | Inpatient                     |                                    |   |                         | rsing Home 5                            | Residence 6 🗸 Othe                             | er: Scene  |
| n of ding Ph  |                | 27. Manner of Death 1 ✓ Natural 5  | Pending 28a. Da   | te of Injury<br>hth, Day,Year | 28b. Time                          |   | ry at Work?<br>Yes 2 No | 28d. Describe                           | how injury occurred                            |  |
| isior<br>Attencer death<br>rector:<br>by the  | icati          | 2 Accident   | Investigation 28e PI  | ace of Injury                 | y - At home, farm, s               | reet, factory, office                       |                         | 28f. Location (                         | Street and Number or R                         | ural Route Number, City                          |
| Divis   | Certification: |  | Could not be determined (Specif                                 |                               |                                    |   |                         | or Town, S                              | State)   |  |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and inplietly filled in by the funeral director, page 2 should be detached for use as the burial - mansi   |                | 29a. Certifier 1 Certifyin   |   |                               |                                    |   |                         |   | se(s) and manner as sta                        |  |
| To the Hos within 24 h To the Fur   | Medical        |  | and manne   |                               | lation and/or investi              | 29c, Licens                                 |                         | ed at the time, date                    | and place, and due to the 29d. Date signed (Mo |  |
|   | 2              | 29b. Signature and title of ce   | Paleir  | $\bigcap$                     |                                    |   | M.E.                    |   | March 31, 2010                                 | , ==9,, ( 99./                                   |
| 0 10  |                | 30 Name and address of pe  | V .   | -                             | th (Item 23a)                      |   |                         |   |  |  |
| R 10  |                | 3ਹੈ-Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |   |                               |                                    |   |                         |   |  |  |
|   | ate            | 31. Date filed (Month, Day, Y  | (ear) 32.   | Registrar                     | Signature                          |   |                         |   |  |  |
| Regist  | reli i         | APR U U LU   | سراستمر مار   |                               |                                    |   |                         |   |  |  |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ April 4, 7:22 P M Julia Geller Sulsky Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Harmony Hall Assisted Living Facility Columbia If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Feb. 21, 1923 Days Hours Min. New York Director 098-12-7681 87 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No MD Howard Columbia 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Funeral U.S.A. 21044 6336 Cedar Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ☐ Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Government Per<u>sonal Administrator</u> 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bess Heimowitz Benjamen P. Geller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Tricount Court Apt. 1C Owings Mills, MD 21117 Paul L. Sulsky/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/7/2010 Olney, Maryland Judean Mem. Gardens Signature of Funeral Service Licensee Kurt Blake 22. Name and Addre Edward Sagel Funeral Direction, Inc. 1170 Rockville pIke, Rockville. Maryland 20852 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Day's and Death Immediate Cause (Final Ph sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Week Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence or). Examin Unknown Atrial Fibrillation attending physician and for use as the burial-transit Due to (or as a consequence of): Unknown Physician/Medical Congestive Heart Failure IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day signed by the atte Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Š cate has been sig Completed Be မ Certificate:

Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

| Part II. Other significant conditions o                                   | ontributing to death but not res | g cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? |  |   |  |  |
|---|----------------------------------|--------------------------|--|--|---|--|--|
| Diabetes, Hyper   | tension, Aorti                   | sease,                   | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown                |  |   |  |  |
| Cardiac Pacemak   | er                               |                          |  | 24a. Was an autopsy performed? 1 □ Yes 2 X No          | 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |  |  |
| 25. Was case referred to medical  |                                  |                          | k only one)  |  |   |  |  |
| examiner?<br>1  Yes 2  No   | Hospital:<br>1 ☐ Inpatient 2 ☐   | ER/Outpatient 3 🔲        | ome 5 Residence 6                                      | e 5 Residence 6 K Other Assidisted Living              |   |  |  |
| 27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation |                                  | 28b. Time of injury      | 28c. Injury at<br>work?<br>1 ☐ Yes 2 ☐ No              | 28d. Describe how injury                               |   |  |  |
| 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined                    |                                  |                          | 28f. Location (Street and<br>City or Town, State)      | 8f. Location (Street and Number or Rural Route Number, |   |  |  |
| 200 Cortifier 1 Cortifuing Phy  | sician: To the best of my knew   | dedge death occured      | at the time, date and place, a                         | nd due to the cause(s) and                             | manner as stated  |  |  |

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

4-6-2010

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 9 2010

Rebecca Elon, MD 6701 North Charles Street, Suite 4105, Baltimore, Maryland 21204

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup>2010 Angela Lynn Souders 2:30PM 4 Medical April 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA 5. Social Security Number **Funeral** . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Months Days (Month, Day, Ye Country) Marvland Hours Min. **Director** 215-80-1897 44 Dec.6, 1965 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 No Maryland Frederick Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1204 Leafy Hollow Circle 21771 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I n and Mental Hygiene, 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ William Lewis <u>Norma Jean Weddle</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Mark E. Souders / Husband 1204 Leafy Hollow Circle, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of I
Important: If ite
any Injury or ot 20c. Location - City or Town, State ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Stauffer Crematory Inc.4/7/2010 Frederick, Maryland 21. Signature of Ineral Service Licens 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21771 23a. Part 1. Enter the disease, or complications in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death I Day Immediate Cause (Final disease or condition resulting in death) Physician/ Hydrocephalus Medical Due to (or as a consequence of): Examiner Gastric Cancer 1 1/2 yearsSequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred To the Hospina. within 24 hours after death.

To the Funeral Director: After a contact of the Funeral Director of the funeral or Attending X Natural injury 5 Pending Division ☐ Accident ☐ Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 D0069695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Grena

10 CENTER DRIVE, BETHESDA, MD 20892

Kiran Lagisetty

APR

31. Date filed (Month, Day, Year,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Anril 2010 6.10 Рм Anna Catherine Stup 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Year If Under 24 Hrs. Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Months 1 ☐ M 2XX May 24, 1924 Mary Tand 215-76-5557 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Walkersville 1 Yes 2 No 10f. Zip Code 21793 10e. Street and Number 10g. Citizen of What Country? 9253 Water Street Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces 1 ☐ Yes 2 X No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Owner/Operator Dairy Farm 17. Father's Name (First, Middle, Last) William Cochran 18. Mother's Name *(First, Middle, Maiden Surname)* Mary Sigler Lakin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Bennett Drive, Thurmont, MD 21788 Patsy Wiles/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State Stauffer Crematory Frederick, MD 4 Donation 5 Other (Specify) 04/12/2010 21. Signature of Funeral Service L Stauffer FuneralHome, PA 40 Fulton Avenue, Walkersville, MD 21793 23a. Part 1. but he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 34 hours resulting in death) Due to (or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that intitled as or injury) Month: that initiated events

Physician/ Medical Examiner

Physician/

Medical

Director

by Funeral

Completed

Be

**Examiner** 

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

inding physician and use as the burial-transit

the Hospital or Attending Physician: The law requires that the death certificate be executed

Records, P.O. Box 68760

Division of Vital

Exami

Physician/Medical

by

Completed

Be ဂ္

Certificate:

Medical

(Check only one) 29b. Signature and tike

30. Name and add

400 (Jest) -31. Date filed (Month, Day, Year)

| resulting in death) Last Due to (or as a consequence of):                                     |  |   |  |   |   |  |  |  |  |  |
|---|--|---|--|---|---|--|--|--|--|--|
| •   | d  |   |  |   |   |  |  |  |  |  |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1                                  |  |   |  |   |   |  |  |  |  |  |
| Part II. Other significant condition  | s contributing to death but not re-  | sulting in the underlying   | g cause given in Part I.                     | 23e. Did tobacco                          | o use contribute to the cause of death?       |  |  |  |  |  |
| Respiration Cilure, altered mental s chus, lactic acidosis 1 yes 2 No 3 Probably 4 Getinknown |  |   |  |   |   |  |  |  |  |  |
| scrip right 14)   | 24b. Were autopsy findings available prior to completion of cause of death?  12                                |   |  |   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)   |  |   |   |  |  |  |  |  |
| 1 Yes 2 No  | Hospital:  | Hospital:  1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:  4 ☐ Nursing Home 5 ☐ Residence |  |   |   |  |  |  |  |  |
| 7. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga                            | tion   | 28b. Time of injury   | 28c. Injury at<br>work?<br>1 ☐ Yes 2 ☐ No    | 28d. Describe how inj                     | jury occurred                                 |  |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   |  | ome, farm, street, facto<br>y)  | 28f. Location (Street a<br>City or Town, Sta | and Number or Rural Route Number,<br>ate) |   |  |  |  |  |  |
| (Check 2 Medical Exa  | Physician: To the best of my know<br>aminer: On the basis of examination<br>Burse Practioner: To the best of m | n and/or investigation, i   | n my opinion, death occurred                 | at the time, date and pla                 | ace, and due to the cause(s) and manner state |  |  |  |  |  |

29c. License number

parke

H0068505

29d. Date signed (Month, Day, Year)

State

ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu

Registrar DHMH 17 Rev 7/2009 son who completed cause of death (Item 23a) (Type, Print)

MEduic 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Anthony Stitcher 6:08 P<sup>M</sup> Medical April 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1011 Bedford Street Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Months Hours Min. (Month, Day, Year) 1 ☑ M 2 □ F 220-10-7966 89 Director 05/29/1920 Marvland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1011 Bedford Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglens. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salesman Confectionary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Frederick Stitcher Nina Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy S. Reed/ Daughter 12023 Kneisley Drive, NE, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Vet Cem @ Rocky Gab 04/14/2010 Flintstone, MD of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ 5-1 disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Pregnant at time of death Day 1 Yes 2 No as been signed by the 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page performed Yes 2 death? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical of Vital the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending Division 1 Yes Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pompleted filled in by 28f. Location (Street and Number or Rural Route Number, Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D22181 April 12, 2010

Registrar

Oke

State

925 Bishop Walsh Road, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar's Signature

Gary L. Wagoner

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4/7/2010 Paraska Seniw 2:21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F (Month, Day, Year) 4/26/1924 Ukraine Director 577-54-2429 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Funeral Director 10d. Inside City Limits 1 X Yes 2 No Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 2105 Ingraham Street 20782 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ☒ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Culinary Coordinator Food Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Demetrius Chorchol Anastasia (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Linger / Daughter 1204 Alta Drive, Sunderland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 4/12/2010 Brentwood, Maryland 21. Signature of Funeral Service License 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23d Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line.

Immediate Cause (Final Atheroszleve tree Corolator Arthury disease or condition Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending s after death. Accident Suicide Investigation 6 Could not be 1 Yes 2 No To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition in the cause of a symination and a proposition and a pr 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date/signed/(Month, Day, Year) 2326 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar APR 1 2 2010 Annual 32. Registrar's Signature

James Kennedy Lightfoot, Jr., 20010 Century Blvd., Germantown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/  $\operatorname{APRIL}^{\mathsf{Month}}$ 2010 TYSON 4:30  $A^{M}$ **MARTHA** Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner PRINCE GEORGE'S ADELPHI HARTLAND NURSING HOME 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** JUNE 7 1 M 2 XF Months Days Hours Min. NORTH CAROLINA 1931 78 Yrs 578-42-7737 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Yes 2 No PRINCE GEORGE'S SPRINGDALE MD 10g. Citizen of What Country? USA 10f. Zip Code Funeral 20774 9433 ARDWICK ARDMORE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Black White etc þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Specify: BLACK 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) PRIVATE CUSTOMER SERVICE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ MAUDE CHRISTIAN LEROY KERR SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20772 4208 STONEY PLACE UPPER MARLBORO, MARYLAND DIAN CARTER/GREAT NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State RIVERDALE, MARYLAND 4/12/2010 4 Donation 5 Other (Specify) RIVERDALE CREMATORY J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Sign Jure of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final evosdevotic Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to for as a consequence of) cause. Enter Underlying Cause (Disease or iinjury page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2¾ No Yes 2 No this certificate 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Wursing Home 5 Residence 6 Other (Specify) 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed within 2 To the I 29b. Signature and title of certifier , MD 10060 Lou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tahmina K. Ahmed, MD, 831 University Blvd. East #27, Silver Spring, Maryland 20903 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

APR 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Turner Bettv Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Hagerstown Washington County Hospital Birthplace (State or Foreign Country)

WV If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Marth, Day Xear) 1924 1 M 2 W 85 219-14-7354 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Washington Clear Spring 1 Yes 2 X No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 14511 National Pike 21722 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 white Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elvra (Simpson) Rice Murice Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21722 14511 National Pike Clear Spring Clifton Turner son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Sunset Memorial Park 1 X Burial 2 Cremation 3 Removal from State 4/8/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Sequentially list conditions, Examine if any, isauing to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death been signed by the a should be detached 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed page 2 s death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ ■ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1- Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioners To the best of my knowledge, de at the time date and slace, and due to the cause's and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIEANTIETAM ST, HAGERSTOWN CHOTAN Woll Date filed (Month, Day, Year)

State

Registrar

APR 0

Registrar's Signature

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital

the Maryland

with

death y

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

and

Baltimore, Maryland 21215-0036

28a-f show

Certification: To 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pagr MRS

APROUS 5 2010 State Registrar

29b. Signature and title of certifier

M.D., 600 Memorial Avenue, Cumberland, MD Noshin Qaisrani, 32. Registrar Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D0064167 29d. Date signed (Month, Day, Year)

April 5, 2010

| Amended #  | #s 20<br>03/31               | )c,<br>/10       | 22; nls,<br>, Allegany Co. <b>Ple</b>  | ase Type or   | Print in                       | Black li                        | ndelible  | nk. En                           | sure A        | All Copie                           | s Ar             | e Leç         | gible.           |   |             |
|--|------------------------------|------------------|--|---|--------------------------------|---------------------------------|---|----------------------------------|---------------|-------------------------------------|------------------|---------------|------------------|---|-------------|
|  |                              |                  | For<br>State<br>Registrar  | State o   | t Marylar                      | •                               | artment o<br><i>tificate o</i>                        |                                  |               | Mental Hy                           | /giene<br>Reg. N | 21            | 010              | 12  | 767         |
|  | ysicia                       |                  | DENVER MERI  |   | SON, S                         | R.                              |   |                                  |               | 2. Date of De<br>Month<br>03        | eath D           | ay 2          | 2010             | 3. Time of 1800                             | Death<br>M  |
|  | Medic<br>xamin               |                  | 4a. Facility Name (if not institution Western MD Re  | n, give street and num                                | ber)                           |                                 | 4b. City, Town  |                                  |               | , 55                                |                  | c. County     | y of Death       |   |             |
|  | neral                        |                  | 5. Social Security Number  |   | 7. Age (In yrs. I              | ast birthday)                   | If Under 1 Ye   |                                  | er 24 Hrs.    | 8. Date of Bir                      | rth              | A             | Cou              | place (State or                             |             |
| 3  | ector                        |                  | 215-16-4908 Usual Residence of Decedent  |   | 8                              | 8 Yrs.                          |   | , I                              |               | 05/23/                              | 1921             |               | Pe               | nńsylva                                     | ınia        |
| Aaryland<br>Ba-f sho   | tified at                    | rector           | PA Sou   | ,<br>ithampton  |                                | y, Town or Lo<br><b>learvi</b>  |   |                                  |               |                                     |                  |               |                  | 10d. Inside Cit<br>1 🗌 Yes                  |             |
| with the M   | st be no                     | Funeral Director | 10e. Street end Number 4079 Chaneysvi  | lle Road  |                                |                                 | 10f. Zip Coo  |                                  |               |                                     | -                | itizen of     | What Cou         | ntry?                                       |             |
| ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  | Examiner must be notified at | ۵                | 11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 █ Widowed 4 ☐ Divorce  | rried Armed For                                       | e                              |                                 | Was Decedent of Yes, specify C                        | uban, Mexic                      | an, Puerto    | ecify Yes or No-<br>Rican, etc.)    | -                |               | ck, White,       |   |             |
| and 21215-00<br>he filed within 72 hours<br>ntal Hygiene.  | M dical                      | Completed        |  | ent's Education<br>lest grade completed)  College (1- | -4 or 5+)                      | (Give                           | dent's Usual Oc<br>kind of work do<br>O NOT use retir | ne during mo                     | ost of work   | ing                                 | 16b. i           | Kind of B     | lusiness Ir      | ndustry                                     |             |
| d 212  | nt, the                      | a l              | 8 17. Father's Name (First, Middle,  |   | -4 Or 5+)                      | Fa                              | ctory W   | 1                                | thor's Nam    | e (First, Middle,                   |                  |               |                  | cturer                                      |             |
| Marylano 2 should be file the and Mental I   | atic eve                     | 10               | Percy Thompson   | ,   |                                | _                               |   |                                  |               | Bennet                              |                  | Surnam        | ·e)              |   |             |
| Mar.<br>2 shoullth and 27 is m   | r traum                      |                  | 19a. Informant's Name/Relations Cody D. Thomps   |   |                                |                                 | ng Address (Stre<br>9 Chane                           |                                  |               |                                     |                  |               |                  | -   |             |
| imore,<br>Page 1 and<br>ment of Hea<br>ant: If item  | or other                     |                  | 20a. Method of Disposition  1X Burial 2 ☐ Cremation  |   | State                          | Place of Dispo<br>emetery, cren | sition (Name of<br>natory or other                    | olace)                           |               | Date                                | 1                |               |                  | own, State                                  |             |
| Baltimore,<br>permit. Page 1 and<br>Department of Hea<br>Important: If item  | any injury or oth            |                  | 4 Donation 5 Other (21. Signature of Funeral Service)  |   | Cha:                           |                                 | 11e Met   |                                  |               |                                     | le F             | Thane<br>uner | eysvi<br>al Se   | lle, P                                      | A-PA        |
| <b>M a a</b>   | E G                          |                  | 23a. Part 1. Enter the disease, of   | . yocke   |                                | <u> </u>                        | 22 W.   | Main S                           | Stree         | t, Ever                             | ett,             |               |                  | 37  | INC.        |
| Physic   |                              | 8 3              | shock, or heart failure. List Immediate Cause (Final disease or condition                                    | only one cause of ea                                  | ch line.                       | ,                               |   |                                  |               |                                     | rrest,           |               |                  | Approximate<br>Interval Betw<br>Onset and D | ween        |
| Med<br>Exam  | dical<br>niner               |                  | resulting in death)  | Due to (  | or as a consequ                |                                 |   |                                  |               |                                     |                  |               |                  |   |             |
| Pe   | sit                          | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury | b. Due to   | or as a conseq                 | ieuce oil.                      |   |                                  |               |                                     |                  |               |                  | <del></del>                                 |             |
| e execut   | urial-trar                   | - 1              | that initiated events<br>resulting in death) Last  | c. Due to (   | or as a consequ                | uence of):                      |   | _                                |               |                                     |                  |               |                  |   |             |
| 68760<br>ertificate be   | is the bu                    | <b>Nedic</b>     |  | d   |                                |                                 |   |                                  |               |                                     |                  |               |                  |   | _           |
| Box<br>death o   | ched for use a               |                  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                      |   | Birth 2 Detainant at time of a | al death 3                      | Ectopic pregn Other (specify                          |                                  |               |                                     |                  |               | ate of deliventh | •   | 'ear        |
| , P.O. es that the igned by t  | be deta                      | ρ                | Part II. Other significant condition   | ions contributing to de                               | eath but not res               | ulting in the u                 | nderlying cause                                       | given in Pa                      | rt I.         |                                     |                  |               |                  | he cause of de                              |             |
| ords w requir  | should                       | Completed        | ATRIO  | F13011  | LATINU                         | 1                               |   |                                  |               | 24a. Was                            | an               | 24b.          | Were auto        | psy findings a                              | vailable    |
| Rec<br>The lar   | r, page 2                    |                  |  |   |                                |                                 |   |                                  |               | 1 🗆 Yes                             | ormed?           | 1             | death?           | mpletion of ca                              | luse of     |
| Vital<br>hysiciar<br>nis certif  | directo                      | To Be            | 25. Was case referred to medical examiner?  1 Yes 2 40   | Hospital:   | Inpatient 2 🗆                  | ER/Outpatier                    | I   | . Place of De<br>Other:<br>4 □ I |               | k only one)<br>ome 5 $\square$ Resi | dence            | 6 □ Oth       | er (Specif       | ()  |             |
| on of<br>ading Pl<br>ath.  | e funera                     |                  | 27. Manner of Death 1 □ Natural 5 □ Pendi 2 □ Accident Invest  | 119   | of injury<br>h, Day, Year)     | 28b. Time of<br>injury          | 255. II   | njury at<br>rork?<br>□ Yes 2 [   |               | 28d. Describe I                     | how inju         | y occurr      | red              |   |             |
| The part of the pa |                              |                  |  |   |                                |                                 |   | er or Rura                       | l Route Numbe | er,                                 |                  |               |                  |   |             |
| Hospital   | sted filled                  | Medical          | (Check 2 Medical   | g Physician: To the be<br>Examiner: On the bas        | is of examination              | and/or invest                   | igation, in my op                                     | oinion, death                    | occurred a    | t the time, date a                  | and place        | e, and du     | e to the ca      | use(s) and mar                              | ner stated. |
| To the within  | comple                       | Σ                | only one) 3 L Certifyin<br>29b. Signature and the of certifie  | g Nurse Practioner:                                   | To the best of m               | y knowledge, c                  |   | t the time, da                   | ate and place | e, and due to the                   |                  |               |                  | Day, Year)                                  |             |
| 9  | +                            | ł                | 30 Name and address of person  | who completed care                                    | e of death (Item               | 23a) (Type, F                   | rint)   | 1313                             | 575           |                                     | P                | A Re          | to               | 29 2  | 010         |
| nx   |                              |                  | Robert Well<br>31. Date filed (Month, Day, Year)   | K. M.D. 1   | 2500                           | 10/10                           | Mbrook  | c Kd.                            | Cy            | mberle                              | 200              | d, h          | JD               | 2150  | 7)          |
| Re   | Stat<br>gistra               | - 1              | 31. Date filed (Month, Day, Year)  | Denus 32. Re  | egistrar' Signa                | parker                          | ·   |                                  |               |                                     |                  |               |                  |   |             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 2010 1905 Рм John Keen Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton 6. Sex 1 M 2 □ F Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days NOV 17. 1918 Hours Min Mary1and Director 200-10-5272 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Maryland Ceci1 Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 175 Cowan Road United States 12. Was Decedent Ever in U.S. Armed Forces? World Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? World

1 X Yes 2 No War II Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. Elementary/Seconday (0-12) College (1-4 or 5+) Staff Manager Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abby V. Richards Marion J. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 175 Cowan Road, Port Deposit, MD Vivian R. Thompson/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 18 remetery crematory or other place)
Friends Burial
Grounds 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Calvert, MD 21. Sign ure of Funeral Service Licenses 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, P.A. 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 5days Medical Examiner cr Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes urector: Atter this certificate has been si in by the funeral director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

241

State Registrar (Check

only one

30. Name and address of person

31. Date filed (Month, Day, Year)

123 Sin

who completed cause of death (Item 23a) (Type, Print)

mo

Registrar's Signature

32.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:15 P M 2010 APRII TURNER MABEL В. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, 5. Social Security Number Year) **Funeral** Months Days Hours 1 □ M 2 😾 F 79 20 1930 NORTH CAROLINA 226-36-4732 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show r than "natural", or items 23a or 28a-f shov 1X Yes 2 No Director PRINCE GEORGE'S UPPER MARLBORO MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20774 14115 MARY BOWIE PARKWAY Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1∐Yes 2K∐No Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 h Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ENTREPRENEUR 11TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BAKER permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev PEARLIE TROY BRYANT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) APRIL BROWN BURGESS/DAUGHTER 14115 MARY BOWIE PARKWAY UPPER MARLBORO, MD 20774 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 4/15/10 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Juneral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) arawny Due to (or as a consequence of): / /Medical Examiner anting ronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Card Wagular de kas Hospital or Attending Physician: The law requires that the death certificate be execute Therosilentre aftending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months 5 Other (specify) 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nis certificate has been signed director, page 2 should be det ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Disibete 2 1No 2 No 1 □Yes 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 21⊈No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 5 ☐ Pending investigation 1 Li Matural i 24 hours after death.

e Funeral Director: Af 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3001 HOSPITAL DR. CHEVERLY MD 20785 30. Name/and address of person who 32. Registrar's Sign 31. Date filed (Month, Day, Year) State APR 1 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Physician/  $\overset{\scriptscriptstyle{\mathsf{Month}}}{\mathsf{APRIL}}$ 5:10 P M THORPE EVEROY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY 15417 LANGSIDE STREET SILVER SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** AUG. 1 1 XM 2 □ F Months JAMATCA 1975 Director 218-63-8457 Usual Residence of Deceden 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No SILVER SPRING MONTGOMERY MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20905 15417 LANGSIDE STREET Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give within 72 hours after Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nit. Page 1 and 2 should be filed within 72 autment of Health and Mental Hygiene. octant. If item 27 is marked other than injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WINNIFRED JOHNSON THORPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15417 LANGSIDE STREET SILVER SPRING, MARYLAND 20905 MARCIA THORPE/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE, MARYLAND 4/10/10 RIVERDALE CREMATORY : J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Signature of Funeral Service Licenses 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ADULT CELL LUKEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death signed by the atte Month Year Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 🗓 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) 2 2 ⋤ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death, Funeral Director; After injury work?
1 Yes 2 No 1 Natural 5 Pendina Accident Investigation filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

within 24 ho

To the Fune

completed fi State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check only one) 29b. Signature and title of certifie

MICHAEL

31. Date filed (Month, Day, Year)

APR 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Recistrar's S

LEIBOWITZ,

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MD 11120 NEW HAMPSHIRE AVENUE # 305 SILVER SPRING, MD 20904

29d. Date signed (Month, Day, Year)

APRIL 9, 2010

29c. License numbe

D08089

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #5. per Fh g902 4/28/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 Physician/ 2010 17:30 eit Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Adventist Hospital Montgomer Park Nashington akoma If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** (Month, Day Months Days 1 XM 2 🗆 F Hours Min. Washington, 2 Yrs. Director 578-50 August Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 ☐ No Maryland Takoma Park Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20912 6618 Poplar Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black. White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Message Clerk Newspaper 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John A. Veit, Sr. (Unav.) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edras Israel Ferrufino / Friend 3341 Buchanan St., Apt #103, Mount Rainier, MD 20712 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/13/2010 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for equence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or " Exami or Attending Physician; The law requires that the death certificate be executed Cause (Disease or ilinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown the underlying cause given in Part,1) Part II. Other significant conditions contributing to death but not resulting 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) itle of certifier 29b. Signature and 29c. License numbe Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Mustafa Kango, 7701 Carroll Avenue, Takoma Park, MD 20912 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 2 2010 Registrar

DHMH 17 Rev 7/2009

# re, Maryland 21215-0036

| To the mospital or Attending Fifysician: The law requires that the death certificate be executed within 24 hours after death. |
|---|
|---|

|  |                            | Pleas   | Se Type or I                                 |  |                       | artment of h                              |                                       | •  | _                 | ibie.                      |   |
|--|----------------------------|---|--|--|-----------------------|---|---------------------------------------|--|-------------------|----------------------------|---|
|  |                            | For<br>State  | State of                                     | iviai yiai i                           |                       | artinent of F                             |                                       |  | 00                | 10                         | 10770   |
|  |                            | Registrar  1. Decedent's Name (First, Middle,   | Last)  |  |                       | tineate of L                              | Catri                                 | 2. Date of Deat                            | eg. No.           | +4                         | 3. Time of Death                              |
| Physicia<br>Medic  |                            | Virginia  | Wilson                                       |  |                       |   |                                       | Aopth.                                     | Pay 2             | Year<br>O II)              | 0905 M  |
| Examin   |                            | 4a. Facility Name (if not institution,  |  | er)                                    |                       | 4b. City, Town, or                        | Location of Death                     |  | 4c. County        | of Death                   |   |
| <u> </u>   |                            | Washington Coun   |  |  |                       | Hager                                     |                                       |  |                   | hingt                      | on  |
| Funeral<br>Director  |                            |   | 6. Sex 7                                     | '. Age (In yrs. Ia                     | ast birthday)<br>Yrs. | If Under 1 Year Months Days               | If Under 24 Hrs.<br>Hours Min.        | 8. Date of Birth<br>(Month, Day,<br>Mar 21 | Year)             | Counti                     | lace (State or Foreign<br>ry)                 |
|  | 4                          | 578-18-7486 Usual Residence of Decedent   |  | 93                                     |                       |   |                                       | Mar. 21                                    | 1917              | Maryl                      | and   |
| land<br>show<br>dat  | tor                        | 10a. State 10b. County  |  | 10c. City                              | y, Town or Lo         | cation                                    | _                                     |  |                   | 10                         | Od. Inside City Limits                        |
| Mary<br>28a-1<br>otifie  | irec                       | Maryland Washin   | gton   | Ha                                     | igerst                | own                                       |                                       |  |                   |                            | 1 🗆 Yes 2 💢 No                                |
| ith with the Maryland<br>ms 23a or 28a-f show<br>must be notified at   | Funeral Director           | 10e. Street and Number  |  |  |                       | 10f. Zip Code                             |                                       | 1  | 10g. Citizen of W | Vhat Count                 | ry?   |
| th wit   | ıner                       | 1175 Profession   |  |  | La                    | 21740                                     |                                       |  | U.S.A.            |                            |   |
| or ite   | by Fu                      | <ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>                     | 12. Was Decede                               | es?                                    | 5. 13.                | Was Decedent of Hi<br>f Yes, specify Cuba | spanic Origin? (Spen, Mexican, Puerto | Rican, etc.)                               |                   | e - America<br>k, White, e |   |
| be filed within 72 hours after death with the Maryland<br>ental Hygiene.<br>ked other than "natural", or items 23a or 28a-f sho<br>ic event, the Medical Examiner must be notified at  | ed b                       | 3 Widowed 4 □ Divorced  | ed 1 🗌 Yes 2<br>If Yes, Give<br>Year or Date | 9S.                                    |                       | 1 ☐ Yes 2 🛣 No                            | Specify:                              |  | Specify:          | White                      | •   |
| "natu  | Completed                  | 15. Decedent<br>(Specify only highes  |  |  | 16a. Dece             | dent's Usual Occupa                       | ation                                 | ina  | 16b. Kind of Bu   | siness Ind                 | ustry   |
| thin 7;<br>than<br>than  | )om                        | Elementary/Seconday (0-12)  | College (1-4                                 | l or 5+)                               |                       | O NOT use retired)                        |                                       | 9  | 17 1              |                            |   |
| Hygie<br>Hygie<br>other  | To Be C                    | 17. Father's Name (First, Middle, La  | l est)                                       |  | L                     | Restau                                    | 18. Mother's Nam                      | o /First Middle A                          |                   | Serv                       | /1ce  |
| be filk<br>ental<br>ked c  |                            |   | ountz  |  |                       |   |                                       |  | Spurgeon          |                            |   |
| nd M   |                            | 19a. Informant's Name/Relationship  |  |  | 19b. Mailir           | ng Address (Street a                      |                                       |  |                   |                            | ode)  |
| d 2 shadth a   |                            | Sandra Wilson   | / Daughte                                    | er                                     | 900                   | Bayberry                                  | Dr. Arno                              | ld, Mary                                   | land 21           | 012                        | ,   |
| permit. Page 1 and 2 should be filed within 72 hours after death v<br>Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items<br>any injury or other traumatic event, the Medical Examiner mu<br>once.                                    |                            | 20a. Method of Disposition  1 Description 2 Cremation 3                                       | 2 Domewal from C                             |  |                       | sition (Name of<br>natory or other place  | e)                                    | Date                                       | 20c. Location -   | City or Tov                | vn, State                                     |
| Page<br>ment<br>tant: I  |                            | 4 Donation 5 Other (Sp  | pecify)                                      | nate                                   |                       | n Cemeter                                 |                                       | /2010 H                                    | lagersto          | wn _ l                     | Maryland                                      |
| permit<br>Depart<br>Import<br>any inj<br>once.   |                            | 21. Signature of Funeral Service Lic  | ensee  |  |                       | . Name and Addres                         |                                       |  |                   |                            |   |
| ⊕ □ = @ 0  |                            | The K.  | de   | <u> </u>                               |                       |   |                                       |  |                   |                            | 71and 21742                                   |
|  |                            | 23a. Part 1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final |  |  |                       |   |                                       |  |                   |                            | Approximate Interval Between Onset and Death  |
| Physician/<br>Medical  |                            | disease or condition<br>resulting in death)   | a. Due to /o                                 | r as a sonsequ                         | W (                   | Hocar                                     | eaeae                                 | 1402                                       | ucqu              | n                          | Onset and Death                               |
| Examiner   |                            |   | Due to to                                    | Hus                                    | -les                  | sti !                                     | Vacult                                | ac De                                      | ime               | _                          |   |
|  | iner                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying            | b. Due to (or                                | r as a consequ                         | ence 🚚                |   |                                       |  |                   |                            |   |
| outed<br>nd<br>ransit  | kam                        | Cause (Disease or iinjury that initiated events   | c  | you                                    |                       | demi                                      | 7                                     |  |                   |                            |   |
| s be executed<br>ysician and<br>e burial-transit   | cal Examiner               | resulting in death) Last  | Due to (or                                   | onsequ                                 | enc (†):              |   |                                       |  |                   |                            |   |
|  |                            | , A.  | d  |  |                       |   |                                       |  |                   |                            |   |
| eath certificate b<br>attending physi<br>I for use as the b  | Ž                          | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outco                           | ome of <u>pr</u> egnar                 | ncy _                 |   |                                       |  | 23d Dat           | e of delive                | D/  |
| eath o   | icia                       | in the past 12 months?  1  Yes 2  No  | 4 Pregna                                     | ant at time of d                       |                       | Ectopic pregnance Other (specify)         | У                                     |  | Mor               |                            | Day Year                                      |
| the d<br>by the  | hys                        | 9 Unknowh   | 9 ☐ Unkno                                    |  |                       |   |                                       |  |                   |                            |   |
| s that<br>gned<br>se det   | Completed by Physician/Med | Part II. Other significant condition  | ' // //                                      | . /                                    | •                     | •   | en in Part I.                         |  |                   | _                          | e cause of death?                             |
| equire<br>een si<br>ould I   | ted                        | _ cysenna   | x yy   | pery                                   | usi                   | on.                                       |                                       | 1 🗆 Ye                                     | es 2 No           | 3 🗌 Prob                   | ably 4 Unknown                                |
| law ru<br>has b<br>e 2 sh  | ag l                       | Chronic k   | id ney                                       | Wes.                                   | eau                   | - Cla                                     | 55 %.                                 | 24a. Was ai<br>autops                      | sy P              | rior to con                | sy findings available<br>npletion of cause of |
| r. The   |                            |   |  |  |                       |   |                                       |  |                   | leath?                     | 2 🗆 No  |
| siciar<br>certif<br>irecto   | Be .                       | 25. Was case referred to medical examiner?  1  Yes 2 No                                       | Hospital:                                    |  |                       | Othe                                      | r:                                    |  |                   |                            |   |
| ding Physician: The la<br>h.<br>After this certificate ha<br>funeral director, page  | e: 1                       | 27. Manner of Death   | 28a. Date of                                 |  | 28b. Time of          | it 3 LI DOA                               | 4 ☐ Nursing Ho                        | ome 5 Reside<br>28d. Describe ho           |                   |                            |   |
| ath.<br>rr; Afte   | licat                      | Natural 5 Pending 2 Accident Investiga  | ation  | , Day, Year)                           | injury                | M 1 🗆                                     | ?<br>Yes 2□No                         |  |                   |                            |   |
| r Atte   | Certificate:               | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | 28e. Place of                                | f Injury - At hor<br>g, etc. (Specify) |                       | eet, factory, office                      |                                       | 28f. Location (Str.<br>City or Town        |                   | r or Rural I               | Route Number,                                 |
| urs af<br>rral Di  |                            |   |  |  | _                     |   |                                       |  |                   |                            |   |
| Hosp<br>24 ho<br>Fune<br>Fune  | Medical                    | (Check 2 L Medical Ex   |  | of examination                         | and/or invest         | tigation, in my opinio                    | n, death occurred a                   | t the time, date an                        | d place, and due  | to the caus                | se(s) and manner stated.                      |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the | Σ                          | 29b. Signature and title of certifier   | Nurse Prectioner: To                         |  |                       | 29c License                               | number                                | 2  | 9d Date signed    |                            |   |
|  |                            | > Main Ell  | Mary 4                                       | 6)                                     |                       | 123                                       | 815                                   |  | 4-1:              |                            |   |
| (1)  |                            | 30. Name and address of person wi   | ho completed cause                           | of death (Item                         | 23a) (Type, F         | DZ3                                       | 1111                                  | 2 2 4                                      | > 0/0             |                            |   |
| 5H-6   |                            | 35 9 Mcl  | 157.   | H49<br>gistrar's Signati               | 21-51                 | TOWN,                                     | . 001/                                | / del.                                     | 770,              |                            |   |
| State<br>Registra  |                            | APR 1 4   | 2010   | jiotrai s olgriati                     | 1. 1                  | all                                       |                                       |  |                   |                            |   |
|  | _                          |   |  | _                                      | 7.7                   |   |                                       |  |                   |                            |   |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Day 2010 Physician/ 3 1304 Alice Williams Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 8, 1915 If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months Days Min. Director 579-28-0816 DC Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Capital Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 6620 Ronald Road Apt. # T-2 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 10th College (1-4 or 5+) Private Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emma Connor Harry G. Tibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capital Heights, Md. 6620 Ronald Road Apt. T-2 and 2 s Health Emma D. Clark/ Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 13, Cemetery, crematory or other place) Quantico National 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Triangle, Virginia 21. Signature of Funeral Service Lie 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1. E. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FATAL CARDIAC Physician/ Medical Due to (or as a consequence of): Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Day Pregnant at time of death Month Year ed by the detached P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X N certificate 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA funeral ( Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completed filled in by the fun 1 Natural work? 5 Pending Division 2 No Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation in my original death and restricted in the cause (s). Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

HOSPITAL 3001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month () Physician/ 4:08PM 2010 OATES WILLIAMS MATTIE MAE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTORS COMMUNITY HOSPITAL LANHAM 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours JULY 25, 1918 1 □ M 2 🗓 F NORTH CAROLINA Director 91 245-36-0749 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland trnett of Health and Mental Hygiene. It ant: If if the 27 51 smarked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No PRINCE GEORGE'S SEABROOK 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6610 U.S.A. 100th AVE. 20706 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify. 3 Widowed 4 Divorced BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC PRIVATE HOMES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ FALLIE CRAWFORD **THOMAS** OATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KITHCART/GRANDSON 100th AVE., SEABROOK, permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti MD. 20706 6610 NATHAN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHAMBERS CREMATORY 4-9-2010 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD. Signature of Funeral Service Licenses 22 Name and Acdress of Facilia HOME & CREMATORIUM, P.A aneway 5801 CLEVELAND AVE., RIVERDALE, MD. M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final PNEUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: for use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c MYUCARDIAL INFARCTION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed Hospital or Attending Physician: The 1 Yes 2 No Yes 2 X No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀No မ 1 Minpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P D47604 Mathew M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOBHAN MATHEW, M.D. 3048 MITCHELLVILLE ROAD, BOWIE MD 207/6

State

Registrar

31. Date filed (Month, Day, Year)

APR 09

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🥍 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 8, 2010 Whitbeck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sunrise Assisted Living Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗷 F Months Days Hours Min. April 3, 1914 124-18-3937 96 Yrs **Director** Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 Funeral USA 11621 New Hampshire Avenue 2 should be filed within 72 hours after death vith and Mental Hygiene.
27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 😿 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Raymond Whitbeck Elizabeth Abramson 19a. Informant's Name/Relationship (Type, Print)

Diana L. Schroeder/ Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9904 Cherry Tree Lane, Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Hurley Cemetery 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hurley,, New York Signature of F Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring ,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Physician: The law requires that the ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, Hypertension, Dementia, Atherosclerotic Cardiovascular Disease 24a. Was an performed? this certificate Yes XX No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Hospital or Attending Pt 24 hours after death. Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a Medical 29a. Certifier only one) Someture and title of conti 29c, License number D12121

3. Time of Death

М

4:15 p

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

New York

White

Approximate Interval Between

Onset and Death

Year

23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 St Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) April 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George F. Sengstack, MD 3929 Ferrara Drive, Wheaton, MD 20906 State 9 arks Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

| Am<br>4/            | end #2<br>13/201   | 20°a<br>10°,                  | a-c,per <sup>FD</sup> , <b>Please T</b><br>CCHD,   | ype or Print i   | in Black I                          | ndelible Ir   | nk. Ensure A                                    | All Copies                            | s Are Leg                            | jible.  |  |
|---------------------|--|-------------------------------|--|--|-------------------------------------|---|---|---------------------------------------|--------------------------------------|---|--|
| dr                  | W  |                               | for<br>State<br>Registrar  | State of Mary  |                                     | partment o<br>ertificate d  |   | Mental Hy                             | ygiene<br>Reg. No. 🤈 🏳               | 110   | 12776  |
| ı                   | Physici  |                               | 1. Decedent's Name (First, Middle, Last) Bette   |  | Whyte                               | ·   |   | 2. Date of D                          | eath                                 | Year  | 3. Time of Death                                   |
| *                   | /Medic<br>Examir   |                               | 4a. Facility Name (If not institution, give s  |  |                                     |   | n, or Location of Deat                          | h                                     |                                      | ty of Death   | 4:1) -   |
| 287"                | Funeral<br>Director  |                               | 1318 Balsam Stree  5. Social Security Number 6. Sex 1□   |  | n <i>yr</i> s. last birthda<br>Yrs. | St. Le  | ar If Under 24 Hrs                              | 8. Date of B                          | Calv<br>71933                        |   | ace (State or Foreign<br>try)                      |
|                     | ס  | L                             | Usual Residence of Decedent  10a. State  10b. County  Maryland  Calvert  |  | Oc. City, Town or                   |   |   |                                       |                                      |   | 0d. Inside City Limits                             |
|                     | vith the Me<br>a or 28a-f  | Directo                       | Maryland Calvert  10e. Street and Number  1318 Balsam Stree  |  | St. Leor                            | 10f. Zip Coo<br>2068  |   |                                       | 10g. Citizen of                      |   | -  |
| 980                 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinat must be notified at | Completed by Funeral Director |  | 12. Was Decedent Ever<br>Armed Forces?<br>1  ☐Yes 2  ☑No<br>If Yes, Give<br>Year or Dates: | r in U.S. 10                        |   | of Hispanic Origin? (S<br>Cuban, Mexican, Puer  | Specify Yes or N<br>to Rican, etc.)   | lo- 14. Ra<br>Bl                     | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: white |  |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce.    | ompleted                      | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | cation e completed)  College (1-4or 5+)  | (Gi<br>life                         | cedent's Usual Oc<br>ve kind of work do<br>b. DO NOT use re<br>Staurant | one during most of wo<br>tired)                 | rking                                 | food s                               |   | •  |
| land                | uld be filed<br>Mental Hy<br>rked othe<br>rtic event,  | To Be C                       | 17. Father's Name (First, Middle, Last) Rudolph Drennan  |  |                                     |   | 18. Mother's Nar<br>Kather                      | me (First, Middle<br>ine Thie         |                                      | ame)  |  |
|                     | and 2 shoi<br>ealth and P<br>n 27 is ma<br>ier trauma  |                               | 19a. Informant's Name/Relationship (Type Michael P. Whyte -  |  |                                     |   | St. St. L                                       |                                       |                                      |   |  |
| Baltimore,          | it. Pages 1 arment of He rtant: if item njury or oth njury or oth  |                               | 20a. Method of Disposition  1 → Burial 2 → Cremation 3 → R  4 → Donation 5 → Other (Specify)   |  | Met ropo                            | in Chape.   | placeApril 1<br>L Cemetery<br>neral Serv        | rice                                  | Lusby,                               | Mary1   | and-   |
| Ba                  | perm<br>Depa<br>Impo<br>any i  |                               | 21. Signature of Euneral Service License   |  | 4                                   | 4405 Bro  | omes Is. R                                      | usch Fur<br>d. Port                   | neral Ho<br>Republi                  | ome P<br>ic , M   | Å·20676  |
| 4                   | Physician<br>/Medical<br>Examiner  |                               | 23a. Part 1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)           | Due to (or as a co   | CVA                                 | anter the mode of   |   |                                       | arrest,                              |   | Approximate<br>Interval Between<br>Onset and Death |
| 68760,              | death certificate be executed<br>e attending physician and<br>d for use as the burial-transit  | ical Examiner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a co   | Demen                               | tia   |   |                                       |                                      |   |  |
| P.O. Box 68         | the death certifics<br>by the attending phached for use as the   | Physician/Medica              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown  | 3c. If yes, outcome of p<br>1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at tim<br>9 ☐ Unknown       | Fetal death                         | 3 ☐ Ectopic pregr<br>5 ☐ Other (specif                                  |   |                                       | T T                                  | Date of delive  | ry<br>Day Year                                     |
|                     | requires that the<br>een signed by the<br>nould be detache   | by                            | Part II. Other significant conditions con  | tributing to death but no  | ot resulting in the                 | underlying cause  | given in Part I.                                |                                       |                                      |   | e cause of death?                                  |
| Vital Records,      | The law<br>ate has b<br>bage 2 sh  | Completed                     |  |  |                                     |   |   | 24a. Wa<br>auto<br>per<br>1 □ Yes     | formed?                              | o. Were autop<br>prior to cor<br>death?<br>1 □ Yes                  | osy findings available npletion of cause of        |
| / Vit               | Physician:<br>this certifical  | o Be                          | 25. Was case referred to medical examiner?  1 Yes 2 No   | ospital:   | 2  ER/Outpat                        | ient 3 DOA  | 26. Place of De<br>Other: 4 ☐ Nursing I         |                                       | one)<br>sidence 6 □C                 | Other (Specifi  | /)   |
| Division of         | Attending Ph<br>ir death.<br>ector: After th<br>by the funeral   | ation: T                      | 27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injury<br>(Month, Day, Ye   | 28b. Time<br>Injur                  | y 1   | njury at<br>Work?<br>1 □ Yes 2 □ No             | 1                                     | e how injury occu                    |   |  |
| Divis               | al or Atte<br>s after des<br>al Directo<br>ed in by th   | Certification: To             | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 28e. Place of Injury -<br>building, etc. (S  | At home, farm,<br>Specify)          | street, factory, offi   | ce  | 28f. Location<br>City or To           | (Street and Num<br>own, State)       | mber or Rura  | l Route Number,                                    |
|                     | To the Hospital or within 24 hours after To the Funeral Dir completely filled in   | Medical (                     | 29a. Certifier (Check only one)  Certifying Phys 2 Medical Examir  | sician: To the best of m<br>ner: On the basis of exa<br>and manner stated.                 | amination and/or                    | eath occurred at the investigation, in r                                | ne time, date and plac<br>my opinion, death occ | e, and due to th<br>urred at the time | ne cause(s) and<br>e, date and place | manner as s<br>e, and due to  | tated.<br>the cause(s)                             |
|                     | vith<br>To t   | Ž                             | 29b. Signature and title of certifier  |  |                                     | _   | ense number                                     |                                       | 29d. Date sign                       |   | Day, Year)   |
|                     | j.   |                               | 30. Name and address of person who co  | mpleted cause of death   | (Item 23a) (Tvn                     | e, Print)   | 50290   |                                       | 4-9                                  |   |  |
| de                  | w 6  |                               | Dhiven Shiv  | 130 HOSP   | RD                                  | Prince  | Fred  | MD                                    | 2067                                 | 8   |  |
|                     | Sta<br>Registr   |                               | 31. Date filed (Month, Day, Year)  APR 0.9   | mpleted cause of death 130 +105 p  | Signature                           | park  |   |                                       |                                      |   |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 04 18 2010 11:45 A M ELIZABETH WILTON JENKINS YOUNG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND 744 WASHINGTON STREET If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1□ M **X**□ F Months Days Hours Yrs. 213-34-5569 10/04/1921 MARYLAND Director 88 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director ALLEGANY CUMBERLAND MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21502 U.S.A. Items 23a 744 WASHINGTON STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Itel 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: þ WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BESSIE SLEEMAN WILLIAM E. JENKINS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. GEORGE G. YOUNG / SON 400 WOODHAVEN END, CUMBERLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/22/2010 4 ☐ Donation 5 ☐ Other (Specify) FNIOMEMENT ROSE HILL MAUSOLEUM CUMBERLAND, MD 22. Name and Address of Facility HAFER FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee 21502 1302 NATIONAL HIGHWAY, LAVALE, MD my 0 23a. Part 1. Enter the diserse or complication; that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It is only one have enter the mode of dying, such as cardiac or respiratory arrest, shock or respiratory arrest, shock of the cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-tran Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 5 ☐ Other (specity) 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 2 **⊡**No 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 | Yes 2 | 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification DO017565 2010 19. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LULIE, MD V AJB311ino ELL NUT MD 31. Date filed (Month, Day, Year) APR 2 3 2010 32. Registrar's Signature State

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31. Date filed (Month, Day, Year) 32. APR 2 6 2010

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Carol Allan, MD

32. Degistrar's Signature

al i

Assistant Medical Examiner

2. Degistrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 17, 2010

10-03111 Shirley Andrews Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| iney Andrew  |                | 1-For State Registrar (   | Certificate of De   |   |  | g. No. 2010  | 12115  |  |  |  |
|--|----------------|---|---|---|--|--|--|--|--|--|
| Physic<br>ledical Exam   |                | Decedent's Name (First, Middle,Last)  | -   |   | Date of Death     Month                    | n<br>Dav Year  | 3. Time of Death<br>1237 hrs                       |  |  |  |
| eulcai Exam  | mici           | Shirley Andrews  4a. Facility Name (if not institution, give street and number)   | 4b. C   | ity, Town, or Location of Dea                                   | April 21, 20                               | 4c. County of Death                                  |  |  |  |  |
|  |                | 3806 Ford Lane Apt. 4   |   | altimore  |  |  |  |  |  |  |
| Funeral<br>Director  |                | 214-50-8874 <sub>1 M 2KF</sub> 60   | · -   | Under 1 Year If Under 24H Ionths Days Hours Mi                  | _  | /1949 Co.  |  |  |  |  |
| any  |                | Usual Residence of Decedent  10a. State 10b. County 10c.  | City, Town or Location                                      |   |  |  | 10d. Inside City Limits                            |  |  |  |
|  | ٦              | MD  | Baltimore   | 2   |  |  | 1 X Yes 2 No                                       |  |  |  |
| the Maryland<br>sa or 28a-f show<br>stiffed at once,   | Director       | 3806 Ford Lane Apt. #4  | 10  | 7. Zip Code<br>21215  | 10   | g. Citizen of What Coun                              | try?   |  |  |  |
| death with<br>or items 2:<br>must be m   | Funeral        | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X  | If Yes, s   | cedent of Hispanic Origin? ( \$<br>pecify Cuban, Mexican, Puerl | Specify Yes or No-<br>o Rican, etc.)       | 14. Race - Americ<br>White, etc.                     |  |  |  |  |
| ırs after<br>ural",  | by             | 3 X Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete:                      |   | 2 X No specify: sual Occupation (Give kind of                   | work done                                  | Specify: Blac  |  |  |  |  |
| )36<br>thin 72 hou<br>te.<br>than "nat   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)  12th   | during most o   | f working life. DO NOT use re                                   |  | Governmen  | •  |  |  |  |
| imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Intent. If litem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  | Be Con         | 17. Father's Name (First, Middle, Last)  IVan Dotson  |   |   | e (First, Middle, M<br>nknown              | laiden Surname)                                      |  |  |  |  |
| D 21<br>should<br>and Mei<br>7 is mai  | ြို            | 19a. Informant's Name/Relationship (Type, Print ) Sabrina Tate / Daughter   |   | Iress (Street and Number or                                     |  |  | Zip Code)  |  |  |  |
| e, M<br>1 and 2<br>Health :<br>item 2  |                | 20a. Method of Disposition 2  | 0090 DL<br>0b. Place of Disposition<br>crematory or other p |   | Date                                       | 20c. Location - City or                              | Town, State  |  |  |  |
| Baltimore,<br>permit. Pages 1 at<br>Department of Hec<br>Important: If ite   |                | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:   |   | ory Cemetery 4  | /29/2010                                   | Memphis,   | TN   |  |  |  |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or oth  |                | 21. Signature of Funeral Service Licensee   | Bian  | and Address of Facility<br>IChi 814 Upshu                       |  |  | 0011   |  |  |  |
| Physician<br>/Medical  |                | 23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.                           |   |   | or respiratory arre                        | st, shock, or heart                                  | Approximate Interval<br>Between Onset and<br>Death |  |  |  |
| Examiner   |                | Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Athero Due to (or as a consequence)                    |   | scular Disease  |  |  | Dodgi  |  |  |  |
|  | er             | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequentially list conditions)                         | ce of):   |   |  |  |  |  |  |  |
|  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence)       | ce of):   |   |  |  |  |  |  |  |
| ecuted<br>and<br>transit   | al Ex          |   |   |   |  |  |  |  |  |  |
| 60,<br>ate be ex<br>hysician<br>e burial   | Medical        | UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of p  | pregnancy   |   |  | 23d. Date of delivery                                |  |  |  |  |
| Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Physician/N    | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of   | 2 Fetal de  | _   | ancy                                       | ,  | ay Year  |  |  |  |
| D. B.<br>trhe de<br>by the<br>ached f  | Phy            | Part II. Other significant conditions contributing to death but n   | not resulting in the under                                  | lying cause given in Part I.                                    | 23e. Did tob                               | pacco use contribute to t                            | he cause of death?                                 |  |  |  |
| b. P. (<br>irres that<br>signed<br>to be det   | d by           | Chronic alcohol abuse   |   |   | 1 Yes                                      | 2 No 3 Prob  | ably 4 🗸 Unknown                                   |  |  |  |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rate detauth.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact).  | ompleted       |   |   |   | 24a. Was a<br>autops<br>perforr<br>1 Yes 2 | y prior to co<br>ned? death?                         | opsy findings available ompletion of cause of      |  |  |  |
| al Relation The ctor, pa   | Be Co          | 25. Was case referred to medical examiner?  |   | 26.Place of Death (Check  |  | 10 10  | 2 110  |  |  |  |
| f Vit<br>Physici<br>er this c  | ToE            | 1 ✓ Yes 2 No  |   | DOA Other Nursi   |  | Residence 6 Other:                                   | Scene  |  |  |  |
| on or<br>ending<br>ath.<br>or: Afte  | tion:          | 1 Natural 5 Pending (Month, Day, Year)  | 28b. Time of Injury   | 1 Yes 2 No  | 28d, Describe no                           | ow injury occurred                                   |  |  |  |  |
| Division Atterns after der ral Directo   | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  | At home, farm, street, fac                                  | tory, office building, etc.                                     | 28f. Location (St<br>or Town, Sta          | treet and Number or Rurate)                          | al Route Number, City                              |  |  |  |
| the Hospi<br>hin 24 hou<br>the Funci<br>npletely fil   | Medical C      | 29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my know one) 2 ✓ Medical Examiner: On the basis of examination | wledge, death occurred a on and/or investigation, i         | t the time, date and place, an<br>n my opinion, death occurred  | d due to the cause<br>at the time, date a  | e(s) and manner as state<br>nd place, and due to the | d.<br>cause(s)                                     |  |  |  |
| 7. wit   | Med            | 29b. Signature and title of certifier   |   | 29c. License number   |  | 29d. Date signed (Mon                                | th, Day, Year)                                     |  |  |  |
|  |                | After Brosse With   |   | O.C.M.E.  |  | April 22, 2010                                       |  |  |  |  |
| λ 🗸  |                | 30. Namé and address of person who completed cause of death ( Melissa Brassell, MD Assistant Medical Exa                                |   | Street, Baltimore, MD   | 21201                                      |  |  |  |  |  |
| S<br>Regis   | tate           | 31. Date filed (Month, Day Year) 32. Recottrar's Sig  | nature  |   |  |  |  |  |  |  |

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|  |  |                 | For State of Marylan  | •                         |   |  | Mental Hyg                             | iene                           | 0 : 0 = 0 0                                     |  |
|--|--|-----------------|---|---------------------------|---|--|--|--------------------------------|---|--|
|  |  |                 | State Registrar   | Cen                       | tificate of l   | Death                                    |  | leg. No. 20                    | 0 12/80   |  |
|  | Physicia<br>Medio  |                 | 1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i><br>Avis Eileen Austin   |                           |   |  | 2. Date of Deat<br>Month<br>APRIL      | Day Year                       | 3. Time of Death  16:03 M                       |  |
|  | Examin   |                 | 4a. Facility Name (if not institution, give street and number) Union Memorial   |                           | 4b. City, Town, o   | r Location of Deat                       | h                                      | 4c. County of Dea<br>Baltimor  |   |  |
|  | Funeral<br>Director  |                 | 5. Social Security Number 6. Sex 7. Age (In yrs. It   | last birthday)<br>82 Yrs. | If Under 1 Year<br>Months Days                                | If Under 24 Hrs<br>Hours Min.            |  | 9. Bir                         | rthplace (State or Foreign                      |  |
|  |  |                 | Usual Residence of Decedent   | 52 116.                   |   | <u> </u>                                 | 111/00/1                               | Atl                            | anta  |  |
|  | f shored   | tor             |   | ty, Town or Loc           |   |  |  |                                | 10d. Inside City Limits                         |  |
|  | e Mar<br>r 28a-<br>notifi  | Director        | MD Carroll Sy   | ykesvil                   | 10f. Zip Code   |  |  |                                | 1 X Yes 2 □ No                                  |  |
|  | n with th<br>is 23a o<br>nust be   | Funeral I       | 7420 Village Rd #13   |                           | 21784   |  |  | 10g. Citizen of What Co<br>USA | ountry?   |  |
| <b>.</b>   | r death<br>or item<br>niner n  |                 | 11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No                      |                           | as Decedent of H<br>Yes, specify Cuba                         | lispanic Origin? (S<br>an, Mexican, Puer | pecify Yes or No-<br>o Rican, etc.)    | 14. Race - Ame<br>Black, Whit  |   |  |
| 8  | urs afte<br>:ural", o  | Completed by    | 3 ☐ Widowed 4 ☑ Divorced If Yes, Give<br>Year or Dates.   | 1                         | ☐ Yes 2 🔀 No  | Specify:                                 |  | Specify: Wh                    | ite   |  |
| 5  | 72 ho<br>n "nat  | nple            | 15. Decedent's Education<br>(Specify only highest grade completed)  | i (Give k                 | ent's Usual Occup<br>ind of work done (<br>) NOT use retired) | durina most of wo                        | rking                                  | 16b. Kind of Business          | Industry  |  |
| 212  | within<br>giene.<br>er tha   |                 | Elementary/Seconday (0-12) College (1-4 or 5+) 12 2   |                           | istrator  |  |  | Steel                          |   |  |
| Baltimore, Maryland 21215-0036   | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | To Be           | 17. Father's Name (First, Middle, Last)  Benjamin Heft  |                           |   | 18. Mother's Na<br>Ferne I               | me <i>(First, Middle, N</i><br>Larnest | faiden Surname)                |   |  |
| Mary   | 2 should<br>th and N<br>27 is ma<br>trauma   |                 | 19a. Informant's Name/Relationship (Type, Print) Bertrand Clark Austin/Son  |                           |   |  |  | City or Town, State, Zi        |   |  |
| e,   | 1 and<br>of Heal<br>item 2   |                 | 20a. Method of Disposition 20b. F   | Place of Dispos           | ition (Name of  | :  |  | 20c. Location - City or        |   |  |
| timo   | t. Page<br>tment c<br>tant: If<br>jury or  |                 | 4 □ Donation 5 □ Other (Specify) Arc  | dent Cr                   | emation   | 04/2                                     | 2/2010                                 | Hanover, M                     | D   |  |
| Bai  | permit<br>Depar<br>Impor<br>any in   |                 | 21. Signature Funeral Serve Lio Insee   |                           | Name and Addre  |  | #N Hano                                | ver, MD 21                     | 076   |  |
| П  |  |                 | 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. | h. Do not enter           | the mode of dyin  | g, such as cardiad                       | or respiratory arre                    | st,                            | Approximate<br>Interval Between                 |  |
|  | Medical  |                 | Immediate Cause (Final disease or condition resulting in death)  a. RESPIRATOR Due to (or as a consequence)                       |                           | Allune  |  |  |                                | 3 day 5   |  |
|  | Examiner   |                 | STROKE  | ience oi).                |   |  |  |                                | 1 PAY   |  |
| _  | sit sd   | Examiner        | Sequentially list conditions, if any, leading to immediate cause Enter Underlying  Cause (Disease or liniury                      |                           |   | 3 DAYS                                   |  |                                |   |  |
|  | be executed<br>sician and<br>burial-transit  | Exa             | Cause (Disease or iinjury that initiated events resulting in death) Last  C. BOPHAGECTOM7  Due to (or as a consequence of):       |                           |   |  |  |                                |   |  |
| 09   | the ste  | dical           | d. ESOPHAGEAL ADENSCARCINOMA  |                           |   |  |  |                                |   |  |
| 687  | certifica<br>nding parase as   | n/Me            | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan   |                           |   |  |  | 23d. Date of de                | livery  |  |
| . Box  | requires that the death certific<br>been signed by the attending<br>should be detached for use as  | by Physician/Me | in the past 12 months?  1 ☐ Ves 2 ☐ No 9 ☐ Unknown  1 ☐ Live Birth 2 ☐ Feta   | ıl death 3 ∐<br>Jeath 5 ☐ | Ectopic pregnand Other (specify)                              | ЭУ                                       |  | Month                          | Day Year  |  |
| <u>о</u> .   | that the<br>ned by<br>detacl   | y Ph            | Part II. Other significant conditions contributing to death but not res   | ulting in the un          | derlying cause giv  | ven in Part I.                           | 23e. Did tob                           | acco use contribute to         | the cause of death?                             |  |
| ds,  | equires<br>een sig<br>ould b   | ted             |   |                           | _   |  | 1 □ Ye                                 | s 2 No 3 P                     | robably 4 Onknown                               |  |
| eco  | sician: The law re<br>certificate has bourector, page 2 sh   | Completed       |   |                           |   |  | 24a. Was ar<br>autops<br>perforn       | y prior to death?              | topsy findings available completion of cause of |  |
| <u>e</u>   | an: Th<br>rtificat<br>rtor, pa   | Be C            | 25. Was case referred to medical  |                           | 26. PI  | ace of Death (Che                        | 1 Yes 2                                | No 1 ☐ Yes                     | 3 2 □ No  |  |
| Ĭ  | hysici<br>his ce<br>Il direc   | ၉               | examiner? 1  Yes 2 No  Hospital: 1  Inpatient 2   |                           | 3 DOA Othe  | er:<br>4  Nursing F                      | lome 5 🗆 Reside                        | nce 6 Other (Spec              | rify)   |  |
| n of   | ding P<br>th.<br>After t<br>funera   | cate:           | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation   | 28b. Time of injury       | 28c. Injun<br>work<br>M 1 🗆                                   | yat<br>:?<br>Yes 2 □ No                  | 28d. Describe how                      | w injury occurred              |   |  |
| Division of Vital Records,   | or Atter<br>fter dea<br>irector;<br>n by the   | Certificate:    | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At ho building, etc. (Specify                         | me, farm, stree           |   | 100 2 2 110                              | 28f. Location (Str<br>City or Town,    | reet and Number or Ru., State) | ral Route Number,                               |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacconditions of the property of the proper |  |                 |   |                           |   |  |  |                                | ated.   |  |
|  | the Ho<br>hin 24 h<br>the Fur  | Medical         | (Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practioner: To the best of my             | n and/or investic         | ation, in my opinio   | on, death occurred                       | at the time, date and                  | d place, and due to the        | cause(s) and manner stated.                     |  |
|  | 70 Wit   |                 | 29b. Signature and title of certifier   | 21. M.I                   | 29c. License  |  | 29                                     | 9d. Date signed (Mont)         |   |  |
|  | '  |                 | 30. Name and address of person who completed cause of death (Item   | 23a) (Type, Pri           | int)  |  |  |                                | , 2010  |  |
|  |  |                 | SHADI AL-BAHRI M.D. 201 1   | E. UNIV                   | ERSITY  | PKWY                                     | BALTIM                                 | ORE MO                         | 21218   |  |
|  | Stat<br>Registra   | e<br>ir         | 31. Date filed (Mogth, Day, Year) 32. Registrary Signat APR 2 6 2010  | back                      |   |  |  |                                |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie ( 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL Year BASSO 6:35PM **Physician** -MANCES MARI 2010 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE REISTERSTOWA UTURECARE CHERRYWOOD NOT | H Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | SEPT 27 1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2XF 8677 Yrs. MARYLAND 14 216 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itema 23a or 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No Director mo REISTERSTOWN BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USH 21136 ROAD HIGH MEADOW Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: WHITE Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) PRINE PANTR-END MANAGER 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be FRANK BIANCA ROSA BALSAMO 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) REISTERSTOWN MO 21136 BEALEFELO 13020 HEIL MANOR MARYANN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State · 4 Donation 5 DOINER (Specify) ENTEMBRIENT DULANEY WALLEY M.G. 4/28/2010 TIMONIUM, MO 22. Name and Address of Facility N ZUMBOWN FIH 4 MON CO 21. Signature of Funeral Service Licensee 6028 SYKESUILLE NO ELDERUSURG MO 21784 23a. Part 1. Briter the disease, or complications that caused the death. D) of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day detached for 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a To the Funeral L To the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 2 Medical Exag 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D27569 MI 30. Name and address 1838 Frenc Tree Rd Print) cause of death (Its 2

DHMH 17 Rev 1/2001

State Registrar APR 26

31. Date filed (Month.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Burke 4:50AM Physician/ Carolyn Apri awendo lur Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Vestminster arrol Certer HOS If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birt 7. Age (In yrs. last birthday) Social Security Number (Month, Day **Funeral** Country) Hours Min. Al Months 310.40.654 **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. 10c. City, Town or Location **Funeral Director** Carroll 1 🗌 Yes 2 No anksDur 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Summer Field Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: If Yes, Give Year or Dates Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Securit esearch Clerk 12th grade 2 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Baltimore, Maryland 2 Elouise Paule W. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore MD 21239 Maraga Gold 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State Woodlawn, MD 110 Woodlawn Centery 05 01 4 Donation 5 Other (Specify) Vausin C. Greene Puneval Savico Road Randailstown MD 21133 . Signature of Funeral Service Licensee sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tre. List only one cause on each line. 23a. Part 1. Enter the dis shock, or heart fail Onset and Death Immediate Cause (Final ASPIRADOM Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HIPOXIC Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or se's consequence of) ysician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical Box 68760 attending physical for use as the b IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live Birth 2 - Fetal death 3 [ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Other (specify) signed by the a d be detached f 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2No 3 Probably 4 Unknown Division of Vital Records, 1 Yes cate has been signated by page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 2 No 1 Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital Other To the Hospina con within 24 hours after death.

To the Funeral Director: After this controlled filled in by the funeral direction. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Gertifying Nurse** § only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tit D2 9301 MD ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 61 FINKS BURG, MD 2970 1)605 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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2-2-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:50 PM AMES BODINE 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner General plumbia HOWARD Howard Course HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1₽M 2□F Months Days Hours Min 137-30-2540 Director 71 2/21/1939 NJ Usual Residence of Decedent the Maryland 10d. Inside City Limits t0h County 10c. City. Town or Location 10a. State 28a-f show ral", or items 23a or 28a-f shov Evanther must be notified at 1 □ Yes 2 No **Funeral Director** DE Sussex Millsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with 443 Woodside Road 19966 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 △Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 21 No If Yes, Give Year or Dates: 1961-63 Specify Completed by Specify 3 ☐ Widowed 4 ☐ Divorced "natural". White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, Inc. Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Bodine ည Mildred Russo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Bodine - Wife 443 Woodside Rd. Millsboro, DE 19966 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4/28/10 Ardent Cremation 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 M00845 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ARDIOMYORATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ssential Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No ed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? 1 Yes 2 No certificate ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√1No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1'Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 0503 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10+1

State Registrar 31. Date filed (Month, Day, Year) 32.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Alan David Bernsohn 20ÎÖ 10:15 P. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours August 4 1 X M 2 - F 214-66-7305 California 56 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9257 Curtis Drive 21045 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black. White, etc. 1 X Never Married 2 Married δ Yes 2 🗶 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Benefit Authorizer Social Security Admin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic ew ဂ Meyer Bernsohn Emily Ehrens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21045 Mark Bernsohn (Brother) 9257 Curtis Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Columbia Memorial Park 4-26-2010 Clarksville, Maryland 21. Signature i Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin KNolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final On t an Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mdnth, Day, 32. Registrar's Signature State Registrar Bark

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 510 AM Physician/ Sandra Month Lee BLEWETT Abri 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard County General Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours March 27 214-78-7187 Maryland Director 39 Usual Residence of Decedent 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21211 U.S.A. 2079 Druid Park Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked Thomas E. Blewett Rose Marie Troxell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Mark Hall 2079 Druid Park Drive Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 and Department of H 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, Maryland 4-23-2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Witzke Funeral Hones, 5555 Twin Knolls Road Inc. Columbia, Maryland 23a. Part 1. Enter the disease, or co wications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Septic shock Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MMUNDCUpprece Swellentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Renor Fullure attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical omenitors hritis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Vasculitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Hypothy widism 1 Yes 2 No Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certify 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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April 20, 2010

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32. Registrar's Signatur

Ca Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per ab 2902 4-76 Feath and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 305PM BOOTH homas 16 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQU Baltimore HOSPITal Roseda 200 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 ፟M 2 □ F Months Hours Min. Nov 10, 1964 Maryland Director 267-45-4023 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Riverthorn Rd. 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medic I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) food industry dishwasher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ann Sue Kinney Thomas Carl Booth Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Mar Middle River, Md Ann True/mother Riverthorn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ♣ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Ronal S. Wade State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death in farction Pnysician/ myocardial disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner perTension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a consquence of Exami ODESITY Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical DMII Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes 2 - No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D0046595

Registrar DHMH 17 Rev 7/2009

State

ORSheila

31. Date filed (Month,

Y O W

3001

30. (Name and address of person who completed cause of death (tem 23a) (Type, Print)

aLong

4-17-2010

Philadelphia Rd Balto mo 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 **Physician** 2:45 P Butler 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PG aured Heart Home Hyattsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 X F 79-86-50 88 Yrs. Director 1-1437 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show t be notified at 28a-f show 1 Yes 2 No Directo MD Heat to sville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 Queens permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, The Medical Examiner must b 20782 by Funeral MaDel 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A No if Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced lac K Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Housewife Home marker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Unknown 19a. Informant's Name/Relationship (Type. Print)
Rose many Mason Church Control 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose many Mason 6420 Allentown Rd Camo Spring ms 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Cremators 4-16-2010 Kiverdale MD FUNERAL HOME INC. N.W DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility m08211 wrish 2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardio vascu **Physician** disease or condition resulting in death) /Medical Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) burial-t Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 □Ectopic pregnancy ō in the past 12 months? Day Year signed by the at d be detached fo 1 Yes 2 No 9 Unknown 5 Other (specify) 9□Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Cognitive Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performe After this certificate or Attending Physician; director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medic and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number 2010

Registrar

30. Name and

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

MO

gistrar's Signature

1160

CHE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 16 PM WILLIAM GABRIEL, BOGLITSCH ARK 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** March 2I 1 X M 2 🗆 212-30-9048 Director 193B Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1213 Carroll Mill Court 21042 USA death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. ò ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White "natural" Completed 3 Widowed 4 Divorced 1950s Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. :ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Francis Boglitsch Minna Klingelhofer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara A. Boglitsch (Wife) 12123 Carroll Mill Ct., Ellicott City, MD 21042 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 4/25/2010 Sykesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility AIGHT FUNERAL HOME & CHAPEL O Box 195 Sykesville, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician SHOCH SEPTIL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events GASTRO- DNTESTIME burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? RETROPERITONEAL 24a. Was an CARCINOMA performed? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) Residence 6 \( \text{Other (Specify, } \) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 2' Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 067127 APR 23 dessel 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Luciano Amado, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

600 N. Wolfe St., Baltimore, MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Ruby Sowers Blackwell Apri 2010 7:00  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore 9. Birthplace (State or Foreign Country) Mary Land Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 04/15/1920 1 M 2 X F 212-18-1892-90 **Director** or 28a-f show 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Lutherville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1506 Norman Avenue 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Office Be 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Surname) unknown ည Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Blackwell/McKenzie 2829 Pine Island Drive, Leesburg, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Services | 04/22/2010 | Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licer 22. Name and Address of Facility Andent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ ION dys Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2 🗌 No g Unknown a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. avestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29d. Date signed (Month, Day, Year) 18/10 MA rawi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 21204 31. Date filed (Month, Day, Year)

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |   |                           | For  | State of M   | arylan                             |                                 | artment of H   |                      | and M                   | lental Hyg                               | giene                               |                                      |  |
|--------------------------------|---|---------------------------|--|--|------------------------------------|---------------------------------|--|----------------------|-------------------------|--|-------------------------------------|--------------------------------------|--|
|                                |   |                           | State Registrar  |  |                                    | Cer                             | tificate of E  | Death                |                         |  | Reg. No. 2                          |                                      | 12790  |
|                                | Physicia<br>Medic   |                           | 1. Decedent's Name (First, Middle,   | m. B   | YNU                                | um                              |  |                      |                         | 2. Date of Dea                           | Day                                 | Vear<br>0/0                          | 3. Time of Death                                   |
|                                | Examin  |                           | 4a. Facility Name (if not institution, of Arus)  | give street and number)  | U Ha                               | 5P                              | 4b. City, Town, or   | Location o           | of Death                | 113                                      | 4c. County                          | of Death                             |  |
|                                | Funeral<br>Director   |                           | 5. Social Security Number 431–62–3272  | 5. Sex<br>1 → M 2 ☐ F  | e (In yrs. Ia<br>76                | st birthday)<br>Yrs.            | If Under 1 Year<br>Months Days                                 | If Under 2<br>Hours  | 24 Hrs.<br>Min.         | 8. Date of Birth<br>(Month, Day<br>Nov 2 | 3, 1933                             | 9. Birthp<br>Count<br><b>0kla</b>    | lace (State or Foreign<br>ry)<br>10ma              |
|                                | nd<br>now   | ŗ.                        | Usual Residence of Decedent  10a. State 10b. County  |  | 10c City                           | , Town or Loc                   | eation   |                      |                         |  |                                     | 1                                    | 0d. Inside City Limits                             |
|                                | farylar<br>8a-f sl<br>lified  | Director                  | MD Anne Ar   | undel  |                                    | enton                           |  |                      |                         |  |                                     | 1                                    | 1 🗆 Yes 2 No                                       |
|                                | a or 2  | i Di                      | 10e. Street and Number   |  |                                    |                                 | 10f. Zip Code  |                      |                         |  | 10g. Citizen of                     | What Coun                            | try?   |
|                                | th with<br>ms 23<br>must  | Funeral                   | 510 Prince Char  |  |                                    | Langu                           | 21113  |                      | 1.0.10                  |  | USA                                 |                                      |  |
| Baltimore, Maryland 21215-0036 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Saa or 28a-1 show mortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show mortant: If item 27 is marked other than "matural", or items 23a or 28a-1 show many injury or other traumatic event, the Medical Examiner must be notified at once. | þ                         | 11. Marital Status 1 ☐ Never Married 2 🖾 Marrie 3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decedent Arrayed Forces? 1 4 Yes 2 1 If Yes, Give Year or Dates.   | No                                 | 1                               | Vas Decedent of H<br>f Yes, specify Cuba                       | n, Mexican           | jin? (Spe<br>, Puerto l | city Yes or No-<br>Rican, etc.)          | Bla                                 | e - America<br>ck, White, e<br>Cauca | etc.   |
| 15-0                           | 72 hou<br>n "natu<br>ledica   | Completed                 | 15. Decedent<br>(Specify only highes   | 's Education   |                                    | 16a. Deced                      | lent's Usual Occup<br>kind of work done of<br>NOT use retired) |                      | of worki                | ng                                       | 16b. Kind of B                      | usiness Inc                          | lustry   |
| 212                            | within<br>giene.<br>er thai   |                           | Elementary/Seconday (0-12)   | College (1-4 or  | 5+)                                |                                 | irity Gua  | rd                   |                         |  | Powerco                             | n                                    |  |
| and                            | ntal Hy<br>ed oth<br>event  | To Be                     | 17. Father's Name (First, Middle, La<br>Denny Freeman  | *  |                                    |                                 |  |                      |                         | e (First, Middle, i                      | Maiden Surnam                       | e)                                   |  |
| aryla                          | ould bud Me   | ľ                         | 19a. Informant's Name/Relationship   |  |                                    | 19h Mailin                      | g Address (Street a  |                      |                         |  |                                     | State Zin C                          | lode)  |
| ž,                             | nd 2 sh<br>ealth a<br>n 27 is<br>ertrau   |                           | Kazuko Bynum/ W  |  |                                    |                                 | cince Cha  |                      |                         |  |                                     |                                      |  |
| lore                           | ye 1 ar<br>it of He<br>if iten<br>or oth  |                           | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation  | 3 ☐ Removal from State   |                                    | ace of Dispo                    | sition (Name of<br>natory or other plac                        | ce)                  |                         | Date                                     | 20c. Location                       | - City or To                         | wn, State  |
| Itim                           | nit. Pagartmen<br>artmen<br>ortant:<br>injury   |                           | 4 ☐ Donation 5 ☐ Other (Sp<br>21. Signatur → Fy eral Service Li  |  | W •                                |                                 | 1 Cremat   |                      |                         |  | Odentor                             |                                      |  |
| Ba                             | permi<br>Depar<br>Impo<br>any ir  | 0 3                       | 1 /et4x h  | Ill  |                                    | j 14                            | bonaldsö<br>411 Annap  | olis                 | Road                    | Odento                                   | on, MD 2                            | ory,                                 | P.A.   |
|                                | Trysician,  | 0 1                       | 23a. Part 1. Enter the disease, or c<br>shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition | complications that cause<br>ly one cause on each lin                       | the death<br>e.<br>Au              | . Do not ente                   | er the mode of dyin $\mathbb{A}e_{\mathbb{A}}$                 | g, such as o         | cardiac o               | r respiratory arr                        | est,                                |                                      | Approximate<br>Interval Between<br>Onset and Death |
|                                | Medical Examiner  |                           | resulting in death)  | Due to (or as  | a consequ                          | ence of):                       | Lasid  | H                    | La h                    | iornh                                    | رفية المراقب                        |                                      |  |
|                                | p #   | niner                     | Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying   | Due to (or as  | a consequ                          | ence of):                       | - 1  | . /                  | - //                    |  | p-p-                                |                                      |  |
|                                | ate be executed<br>ohysician and<br>the burial-transit  | dical Examiner            | Cause (Disease or iinjury that initiated events resulting in death) Last   | c. Due to (or as   | a consequ                          | ence of):                       | Njur   | Υ                    |                         | <u> </u>                                 |                                     |                                      |  |
| 09                             | te be e<br>hysiciar<br>he buri  | dical                     |  | d  |                                    |                                 |  |                      |                         |  |                                     |                                      |  |
| 687                            | eath certifica<br>attending pl  |                           | IF FEMALE:   | 23c. If yes, outcome   | of pregnar                         | ncv                             |  |                      |                         |  | 004.5                               | A = -6 -1 - 1 - 1 - 1                |  |
| Box                            | \$ <b>9</b> 8   | Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  | 1  Live Birth<br>4  Pregnant a<br>9  Unknown                               | 2 🗌 Feta                           | death 3                         | Ectopic pregnand Other (specify)                               | у                    |                         |  |                                     | ate of delive<br>onth                | Day Year   |
| , P.O.                         | requires that the de<br>been signed by the<br>should be detached  | d by P                    | Part II. Other significant condition   | ns contributing to death I   | out not resu                       | ulting in the u                 | nderlying cause gi   | ven in Part I        |                         | 23e. Did to                              | -1                                  |                                      | e cause of death?                                  |
| ords                           | v requir  | oletec                    |  |  |                                    |                                 |  |                      |                         | 24a. Was a                               |                                     | Were autor                           | osy findings available                             |
| Division of Vital Records,     | sician: The law is certificate has bilirector, page 2 s   | Comp                      |  |  |                                    |                                 |  |                      |                         | autop<br>perfor<br>1  Yes                | rmed?                               | prior to cor<br>death?<br>1 🔲 Yes    | npletion of cause of 2 No                          |
| ital                           | sician:<br>certific<br>rector,  | Be                        | 25. Was case referred to medical examiner?  1 ☑ Yes 2 □ No   | Hospital:  |                                    |                                 | _ Oth  | ace of Deat          |                         |  |                                     |                                      |  |
| of V                           | g Physer this neral di  | te: To                    | 27. Manner of Death  | 1 ☐ Inpat<br>28a. Date of inju<br>(Modth, Da                               | irv ,                              | ER/Outpatier<br>28b. Time of    | t 3 □ DOA<br>28c. Injur  | 4 <u>∐ Nu</u><br>yat | $\overline{}$           |  | ience 6 🗆 Oth<br>ow injury occur    |                                      | )  |
| ion                            | ttendin<br>death.<br>stor: Aft<br>/ the fur   | Certificate:              | 1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no  | ation 1/24   | (E)                                | uninjury<br>UN                  | K'M 1□   | Yes 2 🕽              | Νο                      | Fell.                                    | by A                                | ute                                  | )  |
| )ivis                          | al or At<br>s after o<br>I Direct<br>d in by  |                           | 4 Homicide determin  | ned 28e. Place of Injury   | ry - At hol<br>c. (Specify)<br>DmC | λ                               | eet, factory, office   |                      |                         | City or Tow                              | treet and Numb<br>n, State)         | er or Rural                          | Route Number,                                      |
| _                              | to the Hospital or Attending Physician: The law requires that the within 24 hours after death, within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.   | Medical                   | (Check 2 Medical Ex  | Physician: To the best of aminer: On the basis of Nurse Practioner: To the | my knowle                          | edge, death of<br>and/or invest | occured at the time  | , date and p         | curred at               | d due to the cau                         | use(s) and manr<br>nd place, and du | e to the cal                         | d.<br>use(s) and manner stated.                    |
|                                | To the within 2 To the comple   |                           | 29b. Signature and title of certifier  |  | De                                 | eput                            | 29c. License   | number               |                         |  | 29d. Date signe                     |                                      |  |
|                                |   |                           | 30. Name and address of person w   | ho completed cause of a  | leath (Item                        | 23a) (Type 5                    |  | 066                  | 150                     | +  | 4/                                  | 19                                   | 110  |
| 11                             |   |                           | William  | PUJON  | 03,                                | ME                              | 6  | 95                   | -0                      | Ame                                      | rieA                                | 0                                    | 1035   |
|                                | Stat<br>Registra  |                           | 31. Date filed (Month, Day, Year)  | 26 2010 Hegistr  | ars Signat                         |                                 | park   |                      |                         |  |                                     |                                      |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vincent Conrad Chapman Sr. Physician/ Month Day Year 1917 PM 2010 Medical 4a. Facility Name (if not institution, give street and number)
22 South Greene St.
University of Maryland Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 355-24-8526 1 🗚 M 2 🗆 F Min. 979/32 Country) Director Usual Residence of Decedent 28a-f show 10a. State 10b. Count with the Maryland ms 23a or 28a-f shormust be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** AL Montgomery Montgomery Yes 2 🗆 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 536 Old Mitylene Lane 36117 ÚSA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXIo Specify: Completed 3 ₺ Widowed 4 □ Divorced Specify: Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Manager Oil t of Health and Mental Hygier If item 27 is marked other I or other traumatic event, th Be Vaughn 17. Father's Name (First, Joseph 18. Mother's Name (First, Middle, Maiden, Surname)
Leola Darden Chapman ည Page 1 and 2 should be ment of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Chapman, Jr. /Son 7718 Stanmore Drive, Beltsville MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place)
Alabama Heritage Cem 20a. Method of Disposition Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/23/10 Montgomery, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Doda 22 Name and Address of Eachility
Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Idiopathic Pulmonary disease or condition resulting in death) 100,05 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 Li retail God.
Pregnant at time of death in the past 12 months? Dav Yes 2 No ate has been signed by the page 2 should be detached 9 🗌 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 X N 1 ☐ Yes 2 ເNo Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 2 No ပု 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work?
1 Yes 2 No 1 Natural 5 Pending injury s after death. Accident
Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

E

State Registrar 51

P4526

MD

2/20

Baltimore

Walle

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

South Greene

within 2 To the 1 State Registrar

**Assistant Medical Examiner** Pamela E. Southall, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 26 2010

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

and manner stated

29d Date signed (Month, Day, Year)

March 29, 2010

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-02766 State of Maryland / Department of Health and Mental Hygiene Samuel Lee Colbert Certificate of Death 1- For State Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3 Time of Death Physician/ Month Day April 8, 2010 1245 hrs Samuel Lee Colbert Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 342 Highland Drive Glen Burnie 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numbetink 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Sept 1, 1984 25 country Maryland Director 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at some. MD Anne Arundel Glen Burnie Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7887 Tall Pines Ct. 21061 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married Yes Specify: black 1 Yes 2 No specify: 3 Widowed 4 Divorced Yes, Give Year Š 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 polisher maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Lee Colbert Sr. Dorothea Witherspoon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothea Elmore/mother 7887 Tall Pines Ct.; Glen Burnie, Maryland 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 N Other Specify: in State <sup>2</sup>S Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street 21. Signature of Fundal Service Licensee rector It I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician ure. List only one cause on each line (Medical a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disuase or Injury that is Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician be detached for use as the burial o Division of Vital Records, certificate has been rector, page 2 should

δ Completed director Be After this ٩ To the Funeral Director: After t completely filled in by the funeral Certification: within 24 hours after death. To the Funeral Director:

**Medical** 

State Registra

29b. Signature and title of certifie

Carol Allan, MD

|  |   |   | · · · · · · · · · · · · · · · · · · ·                    | 24a. Was an autopsy performed?  1 Yes 2 No                            | 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |
|--|---|---|--|---|---|
| 25. Was case referred to medical   |   | -   | 26 Place of Death (Check                                 | only one)   |   |
| examiner?  1 ✓ Yes 2 No  | spital: 1 Inpatient 2   | ER/Outpatient 3 1                         | OOA Other Nursi  | ng Home 5 Residenc  | ce 6 🗸 Other: Scene   |
| 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation            | FOUND:  | 28b. Time of Injury<br>FOUND:<br>1240 hrs | 28c. Injury at Work? 1 Yes 2 ✔ No                        | 28d. Describe how injury<br>Subject hanged se                         |   |
| 3 ✓ Suicide 6 Could not be determined  | 28e Place of Injury - At ho                                     | me, farm, street, factor                  | y, office building, etc.                                 | 28f. Location (Street and<br>or Town, State)<br>342 Highland Drive, C | Number or Rural Route Number, City<br>Glen Burnie , MD                                  |
| 29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: C | n: To the best of my knowledg<br>On the basis of examination ar | ge, death occurred at the                 | e time, date and place, and<br>y opinion, death occurred | d due to the cause(s) and a<br>at the time, date and place            | manner as stated.<br>e, and due to the cause(s)   |

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

21061

een Onset and

Year

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 V No 3 Probably 4 Unknown

29d. Date signed (Month. Day Year)

April 9, 2010

Death

31. Date filed (Mont 32.

and manner stated

**ORIGINAL** 

| 10-01382             |  |
|----------------------|--|
| Marinrie Chamberlain |  |

| 10-01382   | Please Type or Print in Black Indelible Ink. Ensure All Copies Are   | Legible:   |
|--|--|--|
| Marjorie Chamberla   | State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death   | fue VIV  |
| Dhysisian/   | Registrar  | Reg. No.  Death 3. Time of Death   |
| /Physician<br>Medical Examine  | 1 $1$ $1$ $1$ $1$ $1$ $1$ $1$ $1$ $1$  | Day Year 1637 hrs  |
|  | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death   | 4c. County of Death  |
|  | 6218 Resting Sea Columbia  | Howard   |
| Funeral<br>Director  | Months Days Hours Min  | of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign                               |
| Director   | 578-60-5236 1 M 2 XF 68 Yrs. Montrs Days Hours Min. 7  | 120/4/ Country) JAMACIA  |
| any  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  | 10d. Inside City Limits  |
| <b>*</b>   | IND HOWARD POLUMDIA  | 1 Yes 2 No   |
| more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director   | 10e. Street and Number 10f. Zip Code   | 10g. Citizen of What Country?  |
| h the 3a or totifie  |  | JUMMAIC 14   |
| r death with or items 23 imust be no   | 11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes of International Process)  14. Was Decedent of Hispanic Origin? (Specify Yes of International Process)  15. Was Decedent of Hispanic Origin? (Specify Yes of International Process)  16. Was Decedent of Hispanic Origin? (Specify Yes of International Process)  |  |
| ter de:<br>", or i<br>Ful  | 1 3   Wildowed 4   Divorced in test Give teal 1 1   Yes 21%   No Specify   | Specify: BLACK   |
| nurs aft<br>ntural'<br>amine<br>d by   | 15 December 5 Superior (Specific only bishest grade completed) 15g December 15g Usual Occupation (Sixe kind of work done   | 16b. Kind of Business/Industry   |
| 5-0036 et within 72 hour tygiene. other than "natt the Medical Exan Completed  | Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  | Damestic   |
| within iene.   | 12 4 HOUSE WIFE  | Jon Jan  |
| ID 21215-0036 should be filed within 7 and Mental Hygene. 77 is marked other than matic event, the Medical To Be Comple  | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Mid   | Poblicts   |
| 2121:<br>nould be fil<br>d Mental Is<br>is marked<br>tite event,<br>To Be  | 19a. Informant's Name/Relationship (Type, Print) 415 SAND 19b. Mailing Address (Street and Number or Rural Route   | Number, City or Town, State, Zip Code)   |
| MD and 2 sho alth and m 27 is aumati   | PhIL M. CUANBERLAIN G218 ROSTING SEACH.  | Columbia,MD Z1044  |
| s 1 and of Health  | 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  The purish of the place of Disposition (Name of cemetery, crematory or other place)  | 20c. Location - City or Town, State  |
| imore<br>Pages 1<br>ment of F<br>tant: If i  | 4 Donation 5 Other Specify: ANDENIZ CREMATION 2-22-1   | O HUEN HOVER MD  |
| Baltimore, M<br>permit. Pages I and 2<br>Department of Health<br>Important: If item 2<br>Injury or other traum   | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility How E  10220 Gulleton RG   | IL FUNERAL HOM   |
|  |  | 10 12 12 11  |
| Physician  | 29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator failure. List only one cause on each line.   | Between Onset and Death  |
| Examiner   | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  | 2400   |
|  | Sequentially list conditions, b.   |  |
| iner   |  |  |
| ted<br>Insit<br>Examine  | (Use about this initiated events resulting in death) Last  Due to (or as a consequence of):  |  |
| and<br>transit   |  |  |
|  | UNPENDED AMENDED   |  |
| Box 68760, the death certificate be except the attending physician ched for use as the burial.  Physician/Medic  | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy  | 23d. Date of delivery  Month Day Year  |
| x 68<br>h certi<br>tendin<br>use a:  | past 12 months?    1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (Specify)  |  |
| Boy<br>e death<br>the ath<br>led for   | 1 Yes 2 V No 9 Unknown 9 Unknown   |  |
| Division of Vital Records, P.O. B tal or Attending Physician: The law requires that the d is after death.  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached bertification: To Be Completed by Phyperician.   |  | Did tobacco use contribute to the cause of death?  Yes 2 ✓ No 3 Probably 4 Unknown |
| Records, P.( The law requires tha ficate has been signed to be page 2 should be der  | 249  | Was an 24b. Were autopsy findings available  |
| Cord<br>law rec<br>has be<br>2 sho   |  | autopsy performed? prior to completion of cause of death?                          |
| tal Rection: The lectrificate ector, page  | 1 🗹  | Yes 2 No 1 Yes 2 No  |
| Vital Records ysician: The law requi his certificate has been director, page 2 should o Be Complete  | 25. Was case referred to medical 26 Place of Death (Check only one) examiner?  | 5 Residence 6 ✓ Other Scene  |
| n of Vi<br>ding Physi<br>After this<br>funeral dir   | 1 V Yes 2 No 29- Date of John 29- Time of John 29- John 29- Date of John 29- John 20- John 29- John 20-  cribe how injury occurred  |
| on Carlong ath.  | 1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No Subject   | fell   |
| /iSic<br>r Atte<br>ter der<br>birecte<br>in by t   | 2 V Accident Investigation Feb 15, 2010 1630 Irs  3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Local or To   | ion (Street and Number or Rural Route Number, City                                 |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial-ledical Certification: To Be Completed by Physician/Medic | 4 Homicide determined (Specify) Single Family 6218 Res   | wn, State)<br>sting Sea, Columbia, MD  |
| e Hos<br>r 24 hv<br>e Fun<br>letely  |  |  |
| To the Ho within 24 To the Fu completel  | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.  29b Signature and title of certifier  29c License number   | 29d. Date signed (Month, Day, Year)  |
| 2  | 29b. Signature and title of certifier  29c. License number  O.C.M.E.   | February 16, 2010  |
| £ L  | 30. Name and address of person who completed cause of death (Item 23a)   |  |
| 7  | So, realine and gardess of person who completed cause of death (nem 204)   |  |

State Registrar

Pamela E. Sputhall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

|                            |   |                   | Amedn #5, per  | se Type or Pri<br>Fh g904 6/2  | nt in E<br>5/10<br>arvland               | B <mark>lack In</mark><br>d / Depa        | idelib<br>artmer                          | le Ink              | <b>c. Ensur</b><br>lealth an                  | e Al                      | l Copies                           | s Are   | Legi             | ible.                 |   |                     |
|----------------------------|---|-------------------|--|--|--|---|---|---------------------|---|---------------------------|------------------------------------|---|------------------|-----------------------|---|---------------------|
|                            |   | -1                | For<br>State<br>Registrar  | Oldio o. W.  | J. J. J. J. J. J. J. J. J. J. J. J. J. J | Cer                                       | tificat                                   | e of E              | Death   |                           |                                    | Reg. No.  | '711             | 10                    | 127   | 95                  |
|                            | Physicia  |                   | 1. Decedent's Name (First, Middle,   |  |  |   |   |                     | -   |                           | 2. Date of Dea                     | ath<br>23 <sup>a</sup>  | 201              | Year                  | 3. Time of E                                |                     |
|                            | Medic   | al                | Kenneth E. Carf  4a. Facility Name (if not institution,  |  |  |   | 4b City                                   | Town or             | Location of D                                 | )eath                     | April                              |   |                  | of Death              | 10:18                                       | P_ M                |
|                            | Examin  | er                | Gilchrist Hospi  |  |  |   |   | wson                |   |                           |                                    | _   | Balti            |                       |   |                     |
|                            | Funeral<br>Director   |                   | 5. Social Security Number 219 - 52 - 6233  | 6. Sex 7. Ag   | je (In yrs. la<br>60                     | st birthday)<br>Yrs.                      | 8. Date of Birth 9. Bi<br>04779910949 Mar |                     |   |                           | place (State or<br>try)<br>and     | Foreign   |                  |                       |   |                     |
|                            | and<br>show   | , h               | Usual Residence of Decedent  10a. State 10b. County  |  |  | , Town or Loc                             |   |                     |   |                           |                                    |   |                  |                       | 10d. Inside City                            |                     |
|                            | e Maryl<br>r 28a-f<br>notifie   | Funeral Director  | Md Carro   | 011  | Wo                                       | oodbine                                   |   | Code                |   |                           |                                    | 10a, Cit  | izen of W        | Vhat Cou              | 1  Yes                                      | 2 No                |
|                            | with th   | eral              | 1165 Breiten Ct  | t.   |  |   |   | 797                 |   |                           |                                    | USA   |                  |                       |   |                     |
| 36                         | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The math and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show in the 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the M-dical Examiner must be notified at | by                | 11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced  | ied 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates. |  | 11  | f Yes, spe                                | cify Cuba           | ispanic Origin?<br>n, Mexican, Pi<br>Specify: | ? (Spec<br>uerto <b>R</b> | ify Yes or No-<br>ican, etc.)      | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White |                  |                       | etc.  |                     |
|                            | natura<br>dical E   | Completed         | 15. Deceder<br>(Specify only highe   | nt's Education<br>st grade completed)                                      |  | 16a. Deced                                | kind of wo                                | rk done c           | ation<br>during most of                       | workin                    | g                                  | 16b. K  | ind of Bu        | ısiness In            | dustry                                      |                     |
| 121                        | ithin 72<br>ene.<br>r than<br>the M   | Com               | Elementary/Seconday (0-12)   | College (1-4 or 4Yrs.  | 5+)                                      |   | o <i>notu</i> s<br>l <b>As</b> s          |                     | nt Sec  | reta                      | ary                                | Trea  | sur              | y Dej                 | pt.   |                     |
| Maryland 21215-0036        | be filed w<br>ental Hygi<br>ked other<br>ic event, t  | To Be             | 17. Father's Name (First, Middle, L<br>Armond H. Carf  |  |  |   |   |                     | 18. Mother's<br>Glady                         |                           | (First, Middle,<br>nith            | Maiden  | Surname          | )                     |   |                     |
| Mary                       | d 2 should<br>aith and M<br>1 27 is mai<br>er traumat   |                   | 19a. Informant's Name/Relationsh<br>Deborah J. Car:  |  |  | 19b. Mailir<br>1165                       | ng Addres<br>Brei                         | s (Street a<br>.ten | end Number o<br>Ct. Wo                        | or Rural                  | Route Numbe<br>ine, Md             | er, City or<br>21   | Town, S<br>797 • | tate, Zip             | Code)                                       |                     |
| Baltimore,                 | Page 1 an<br>ment of He<br>ant: If iter<br>ury or othe  |                   | 20a. Method of Disposition  1  Burial 2 Cremation 4 Donation 5  Other (S   | 3 ☐ Removal from State   |  | Place of Dispo<br>emetery, cren<br>l Coun | natory or i                               | other place         | ion 04  |                           | ate<br>/2010                       | l .   |                  | City or To            | own, State                                  |                     |
| Balti                      | permit. Page 1 Department of Important: If it any injury or o   |                   | 21. Signature of Fund al Service L   | icepsee  |  | 22  | Name a                                    | nd Addres           | ss of Facility                                | Hai:<br>kes               | ght Fur<br>ville.N                 | nera.<br>Md.  | 1 Hot<br>2178    | me &<br>4.            | Chape1                                      |                     |
|                            | Inysician/<br>Medical<br>Examiner   |                   | 23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)                          | complications that cause only one cause on each line.  a. Due to (or as    | the.                                     | liano                                     | er the mod                                | de of dyin          | g, such as car                                | rdiac or                  | respiratory ar                     | rrest,  |                  |                       | Approximate<br>Interval Betw<br>Onset and D | veen                |
| 00                         | ath certificate be executed attending physician and for use as the burial-transit   | dical Examiner    | Sequentially list conditions if any, leading to immediate cause. Firster Inderthin, Cause (Disease or linjury that initiated events resulting in death) Last | b. Due to (or as   |  |   | -   |                     |   |                           |                                    |   |                  | - 2                   |   |                     |
| . Box 68760                | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi    | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcom<br>1   | 2 Feta                                   | aldeath 3                                 | ☐ Ectopic<br>☐ Other (s                   |                     | су  |                           |                                    |   |                  | ite of deli           | •   | 'ear                |
| s, P.O.                    | requires that the de<br>been signed by the<br>should be detached  | þ                 | Part II. Other significant condition   | ons contributing to death  | but not res                              | sulting in the u                          | underlying                                | cause gi            | ven in Part I.                                |                           |                                    |   |                  |                       | the cause of de                             |                     |
| Division of Vital Records, | he law requi<br>te has been<br>age 2 shoul  | Completed         | -  |  |  |   | _   |                     |   |                           | 24a. Was<br>auto<br>perf<br>1  Yes | psy<br>ormed?   |                  | prior to co<br>death? | opsy findings a ompletion of ca             | vailable<br>ause of |
| aiF                        | ian: Ti<br>ertifica<br>ctor, p  | BeC               | 25. Was case referred to medical examiner?   |  |  |   |   |                     | lace of Death                                 | <del></del>               | only one)                          |   |                  |                       | - 2/  |                     |
| Ę.                         | Physic<br>this ce<br>al dire  | 은                 | 1 ☐ Yes 20 No<br>27. Manner of Death   | Hospital:<br>1  Inpa   |  | ER/Outpatie                               |   | Oth<br>28c. Inju    | 4 L Nurs                                      | -                         | me 5 Res                           |   |                  |                       | in HOSPIC                                   | <u> </u>            |
| o u                        | nding I<br>tth.<br>: After<br>e funer   | icate             | Natural 5 🗆 Pendi  | (Manth D   |  | injury                                    | М   | wor                 |   | - 1                       | od, bosonso                        | now inju  | , 0000           |                       |   |                     |
| Divisio                    | To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page   | Certificate:      | 3 Suicide 6 Could<br>4 Homicide detern   | not be 28e. Place of Ir  | njury - At he<br>etc. (Specif            | ome, farm, str                            | reet, facto                               | ry, office          |   |                           |                                    | on (Street and Number or Rural Route Number,<br>Town, State)        |                  |                       | er,   |                     |
| _                          | Hospits 4 hours Funeral ted fille   | Medical           | (Chock 2 Medical   | g Physician: To the best of<br>Examiner: On the basis of                   | evaminatio                               | n and/or inves                            | stigation, in                             | niao vm r           | ion. death occu                               | urred at                  | the time, date                     | and place   | e, and du        | ie to the c           | ause(s) and ma                              | nner stated.        |
|                            | fo the<br>vithin 2<br>fo the I  | ž                 | only one) 3 Certifying 29b, Signature and title of certifie  | g Nurse Practioner: To th  | e best of m                              | ny knowledge,                             | death occ                                 | urred at th         | ne time, date a<br>se number                  | na place                  | e, and due to t                    | ne cause  | s) and m         | anner as              | , Day, Year)                                |                     |
|                            | F > F 0   |                   | Deports 5  | To ITTE Par C  | PNIF                                     | )   |   | RIC                 | 15356   | )                         |                                    | Apin  | 12               | 412                   | OIC   |                     |
|                            | 101   |                   | 30. Name and address of person   | who completed cause of   | death (Iter                              |   |   | - `                 | ^ (   | æ                         | 2 -                                |   |                  | M                     | 2120  | 4                   |
|                            | Sta   |                   | 31. Date filed (Month, Day, Year)  | 32. Regis  | trar's Signa                             |   |   | erte                | ۱ ۱ ۱ ۱                                       | NC                        |                                    | 200   | ∠! \             | 1740                  | 4100  | 1                   |
|                            | Registr   | (2)               | APR 26 2010  | The reserve  | 19 1                                     | BAL Had                                   |   |                     |   |                           |                                    |   |                  |                       |   |                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. Dededent's Name (First, Middle 2. Date of Death 3. Time of Death Physician/ 9:15 P M Hor: 2010 Medical 4b. City, Town, or Location of Death Examiner Baltimore 70wson HOSPi ce Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) Yrs. 9. Birthplace (State or Foreign **Funeral** Month Cay Hours Country) ND 1 M 2 216-62 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number aja17 Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes ⊅ No ð 1 Never Married 2 Married 1 🗌 Yes 2 **Specify**: Maryland 21215-0036 Specify: Bac permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO OT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Onday (0-12) College (1-4 or 5+) suran Be 18. Mother's Name (First, Middle, 101 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 and Department of H 1 Burial 2 Cremation 3 Removal from State cemetery, cremator injury or 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner MONTHS ZULR Sequentially list nandifians if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and I for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P,O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No hours after death. Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DANIEUE-OUR

31. Date filed (Month, Day, Year)

1 MD (0 70)
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1)630AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 74 Maryland 217 30 3056 1935 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1405 Church Street 21226 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Clerk 1 and 2 should be filed within of Health and Mental Hygiens fitem 27 is marked other th Accounting permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emil Cisar (not available) Rost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tychon Dobrodey / Husband 1112 Church Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 04/26/2010 Baltimore, Maryland Cedar Hill Cemetery 4 Donation 5 Other (Specify) 21. Signatura f Fu 22. Name and Address of Facility Gonce Funeral Service, P.A. eral Service Lice 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 You No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X**Ro 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' death. 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signaty and title of certifie 20d Date sifted (Month. 29c. License numbe Day, Year

State Registrar repleted cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stanley Dietz Martin April 6:00 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Randolph Hills Nursing Home Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days New York Months (Month Day, Year) 01/21/1927 Director 83 577-40-1941 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19964 Fisher Avenue 20837 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify. Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Attorney Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dietz Theresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne Bowes-Dietz / Wife 19964 Fisher Avenue, Poolesville, MD 20837 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 4 Donation 5 Other (Specify) 04/07/2010 Hanover, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician Rectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ detached for in the past 12 months? Month 2 No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hypertension 1 Yes 2 No 3 Probably 4 Number To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus autopsy perform Hypothyroidism 1 ☐ Yes 2 🗓 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🔀 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 🛭 Natural 5 Pending injury Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/21/2010 D56691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Ghousia Sultana,

APR 26

31. Date filed (Month, Day, Year)

M.D

32. R

P.A

DHMH 17 Rev 7/2009

12107 Heritage Park Circle, Silver Spring, MD 20906

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 1 1111 | Robert Dute  |                            |  | ment of Health and Mental Hyglene<br>ficate of Death Reg. No.  | 2010 12799  |
|--------|--|----------------------------|--|--|---|
| Ma     | Physici  | an/                        | Decedent's Name (First, Middle,Last)   | 2. Date of Death<br>Month Day  | 3. Time of Death  Year  0238 hrs                                |
| ivie   | dical Exam   | iner                       | Tim Robert Duter  4a. Facility Name (if not institution, give street and number)                                     | April 21, 2010  4b. City, Town, or Location of Death  4c. City   | County of Death   |
|        |  |                            | Carroll Hospital Center  |  | arroll  |
|        | Funeral<br>Director  |                            | 5. Social Security Number 6. Sex 7. Age (In yrs. last  | Months Days Hours Min.   | D/YYYY) 9. Birthplace (State or Foreign                         |
|        | Director   |                            | 219-74-5924   1 M 2 F   50   | Yrs.   July 5, 19  | 059 Country) Alaska   |
|        | any  |                            |  | wn or Location   | 10d. Inside City Limits   |
|        | land<br>f show   | ō                          | Maryland Carroll   | New Windsor  | 1 X Yes 2 No  |
| n      | e Mary<br>or 28a-<br>ied at  | Director                   | 10e. Street and Number   |  | on of What Country? U.S.A.                                      |
| 1      | imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tatis is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at once.  |                            | 3286 Kaylan Court  11. Marital Status  12. Was Decedent Ever in U.S.   |  | 4. Race - American Indian, Black,                               |
| i      | death<br>or item   | Funeral                    | 1 Never Married 2 Married Armed Forces? 1 Yes 2 No   | If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  | White, etc.   |
| /      | 2 hours after "natural",   | þ                          | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16 |  | pecify: White nd of Business/Industry                           |
|        | 72 hour<br>n "natr<br>al Exa   | Completed                  | Elementary/Secondary (0-12) College (1-4 or 5+)  | during most of working life. DO NOT use retired)   | id of Basinossimadoay   |
|        | 5-0036 ed within 7. Hygiene. other than the Medical  | dmo                        | 12 2   | flooring installer   | building  |
|        | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica  | Be Co                      | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name (First, Middle, Maiden Su  | urname)   |
|        | 212<br>ould be<br>d Ment<br>s mark   | To B                       | Richard W. Duter  19a. Informant's Name/Relationship (Type, Print )  | 19b. Mailing Address (Street and Number or Rural Route Number, City  | or Town, State, Zip Code)                                       |
|        | MD and 2 sh alth and 2 in 27 in an   |                            | Lynda M. Duter/ wife  20a. Method of Disposition  20b. Plac  | 3286 Kaylan Ct. New Windsor, per of Disposition (Name of cemetery, Date 20c. Lo.   | MD 21776<br>ccation - City or Town, State                       |
|        | Ore,<br>ges l a<br>t of He<br>I f ite  |                            | 1 Bunal 2 Cremation 3 Removal from State crem  | natory or other place)   |   |
|        | it. Paratment ortant   |                            | 4 Donation 5 Other Specify: All (  | County Cremation   4/26/2010   Sy<br>  <sup>22. Name and Address of Facility</sup> Hartzler Funer  | ykesville, MD   |
|        | Per Per Injurie  | d                          | attaine O. Harbler   | 310 Chirch St. New Windsor.  | MD 21776  |
|        | Physician<br>√/Medical   |                            | 23a. Part I. Enter the disease, or complications and caused the death. Do failure. List only one cause on each line. | onot enter the mode of dying, such as cardiac or respiratory arrest, shock   | Between Onset and   |
|        | Examiner   |                            | Immediate Cause (Final disease or condition resulting in death)  Atheroscleroti  Due to (or as a consequence of):    | c cardiovascular disease   | Death   |
|        |  |                            | Sequentially list conditions, b  |  |   |
|        |  | iner                       | if any, leading to immediate cause. Enter Underlying Cause  (Disease of initial that initiated cause)                |  |   |
| W      | o B isi  | Physician/Medical Examiner | events resulting in death) Last Due to (or as a consequence of):   |  |   |
| 4-1    | Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit  | ical                       | UNPENDED AMENDED 2.7   | T 000 //00/10 TT   |   |
|        | 760,<br>cate be<br>physical  | /Med                       | if FEMALE. [250, if you, outcome or pregnan  |  | Date of delivery  |
|        | certification ce | cian                       | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death                          | 2  | Nonth Day Year  |
|        | BOY<br>e death<br>the att  | hysi                       | 1 Yes 2 No 9 Unknown 9 Unknown   |  | · · · · · · · · · · · · · · · · · · ·                           |
|        | that th<br>detach  | by P                       | Part II. Other significant conditions contributing to death but not result   | and at the distance of the state  se contribute to the cause of death?  No 3 Probably 4 V Unknown |
|        | rds, requires  |                            |  | 24a. Was an  | 24b. Were autopsy findings available                            |
|        | e law r<br>e has b<br>ge 2 sh  | Completed                  |  | autopsy<br>performed?<br>1 ✔ Yes 2 No  | prior to completion of cause of death?  1  Yes 2 No             |
|        | Vital Records ysician: The law requi   |                            | 25. Was case referred to medical   | 26.Place of Death (Check only one)   | 1 Yes 2 No  |
|        | Nits<br>Physician<br>rthis co  | To Be                      | Tes 2 No   | VOutpatient 3 DOA Other Nursing Home 5 Residence   |   |
|        | n of<br>iding Pl<br>h. After<br>e funera   | ü                          | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28  | tb. Time of Injury   28c. Injury at Work?   28d. Describe how injury   1   Yes 2   No  | r occurred  |
|        | r Atter<br>r Atter<br>ler deat<br>irector<br>n by th   | ficat                      | 2 Accident Investigation 28e. Place of Injury - At home  | e, farm, street, factory, office building, etc. 28f. Location (Street and  | Number or Rural Route Number, City                              |
|        | Div<br>pital o<br>ours aft<br>ieral D<br>filled i  | Certification:             | 4 Homicide determined (Specify)  | or Town, State)  |   |
|        | Division of Yor the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral   |                            |  | death occurred at the time, date and place, and due to the cause(s) and r<br>or investigation, in my opinion, death occurred at the time, date and place   |   |
|        | To t<br>with<br>To t   | Medical                    | and manner stated.  29b. Signature and title of ceptifier  |  | ate signed (Month, Day, Year)                                   |
|        |  |                            | ( / antoleum)  | O.C.M.E. April 2   | 21, 2010  |
|        | $\phi$   |                            | 30. Name and address of person who completed cause of death (Item 23)  |  |   |
|        | 7  | 2010                       |  | 111 Penn Street, Baltimore, MD 21201   |   |
|        | Regis  | tate<br>trar               | 31. Despried Month, Day, Year) Sense 32. Registras s Signature   | Kel  |   |

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Reginala E1110++ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death hever Prince Georges Hospital Prince orger 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months Hours Min. Director 238-76-003 Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Prince George mitchellville Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Bald Hill Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? permit. Page 1 and 2 should be filed within 72 hours after collepartment of Health and Mentar Hyghen. Important I iden 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinanty injury or other traumatic event, the Medical Examinanty in the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event, the Medical Examination and injury or other traumatic event. 1 Never Married Married þ Maryland 21215-0036 1 Yes Yes No Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government ounselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Elliott mitchellville 0303 Bald Hil Rd Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 27/2010 4 Donation 5 Other (Specify) Harmony Cemeery 21. Signature of Funeral Service Licensee NW Wash 814 Upshur ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ erebrovascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Derfension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events death certificate be executed attending physician and for use as the burial-transit nabetes Mellites resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year been signed by the should be detached g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 Tes Other: ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗍 To the P within 2 To the P only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 10694 Campus Way So. Largo MD 20774 Kim 31. Date filed (Month, Day, Year) 32. Reastrar s Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Fincham Physician/ Joy R. 1:07A M April 25° 20°0 Medical 4a. Facility Name (if not institution, give street and number)
Carroll Hospice Dove House 4b. City. Town, or Location of Death 4c. County of Death
Carroll Examiner Westminster . Age (In yrs. last birthday) 80 yre Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign PA PA 1 □ M 2 🔀 F Months Days Hours 6 (Manth, Day, Year) 9 216-24-7455 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Westminster 1 Yes 2 No 10e. Street and Number
5 Timber Ridge Dr. 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 USA death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married within 72 hours after Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White "natural", 3 ₺ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Glass Crafter Be 17. Father's Name (First, Middle, Last)
William Grissinger 18. Mother's Name (First, Middle, Maiden Surname) Dolly Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Donlan-daughter Baumgardner Rd., Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Loudon Park Cem. 1 Burial 2 Cremation 3 Removal from State 4/28/10 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 homas 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. nter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Yea Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown detached 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Hospital or Attending Physician; The law requires Completed 2 No 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Νo Other: ပ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Experience: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Prantian on To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of ce

Name and address of person

o completed cause of death (Item 23a) (Type, Print)

29c. License number

UBSTMI WSTER

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>010</u> **Physician** 11:54P 21 April JOHN HENRY FEELEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Oak Crest Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. April 28, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Maryland 1 **X** X 2 □ F 215-12-9559 87 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f sho the Misclast Evantiner must be notified at 1 ☐ Yes 🏋 No Maryland Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No WW I I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2**XX**No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Feelev ဂ Elizabeth Kelm and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau John Anthony Feeley Son 8511 Tallwood Road Lutherville, Maryland 21093 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens April 26,2010 Timonium, Maryland Donation 5 Other (Specify) 22. Name and Address of FaMTtchell-Wiedefeld Funeral Home Inc gnature of Fene 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 5 ☐ Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐ No within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check online) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Division of Vital Records,

Baltimore, Maryland 21215-0036

P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

acece moranes

BBAZIER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

DHMH 17 Rev 1/2001

WALThea

29c. License number

#R067343

PARKVIlle, MD.

4-22-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| James Ford   |          | - For State   | St   | ate c             | of Maryla                 | and /                  |  | ment of<br>ficate of | Health an<br>Death             | d Mental         |                                     | Reg. No           | . 2010                           | 1 1280  |
|--|----------|---|--|-------------------|---------------------------|------------------------|--|----------------------|--------------------------------|------------------|-------------------------------------|-------------------|----------------------------------|---|
| Physician  |          | Registrar<br>1. Decedent's Name                                 | e (First, Middl  | le,Last)          |                           |                        |  |                      |                                |                  | 2. Date of De                       | eath              |                                  | 3. Time of Death                              |
| Medical Examine  | T        | James Fo  | rd   |                   |                           |                        |  |                      |                                |                  | April 8, 2                          | Day<br>2010       | Year                             | 1316 hrs                                      |
|  | ľ        | 4a. Facility Name (it<br>Johns Hopk                             |  |                   | street and nu             | mber)                  |  | 4                    | b. City, Town, or<br>Baltimore | Location of Do   | 4c. County of Death                 |                   |                                  |   |
| Funeral  | 1        | 5. Social Security N  | umberunk   | 6. Sex            |                           | 7. Age                 | (In yrs. last                                      | birthday)            | If Under 1 Yea                 |                  |                                     | Birth (MI         | Cor                              | hplace (State or Foreign                      |
| Director   | 1        |   |  | 11                | M 2_F                     |                        | 38   | Yrs.                 | Months Day                     | s Hours          | Min.<br>April                       | 9,                |                                  | yland   |
| •  | -        | Usual Residence of  |  |                   |                           |                        | 0.01.7   |                      |                                |                  |                                     |                   |                                  | 10d. Inside City Limits                       |
| w any  |          | 10a. State<br>MD  | 10b. County<br>Balt  | timo              | re                        | ľ                      | IUC. City, I o                                     | wn or Location       | on                             |                  |                                     |                   |                                  | 1 Yes 2 K No                                  |
| land land once.  | <u> </u> |   |  |                   |                           |                        |  |                      | 101 71 0 1                     |                  |                                     | 10 0              | (14/1-1-0                        |   |
| the Maryland<br>a or 28a-f sh<br>tified at once  | 3        | 10e. Street and Nun   |  |                   |                           |                        |  |                      | 10f. Zip Code                  |                  |                                     | J                 | itizen of What Coun              | try?  |
| ith the 23a o notifi   |          | 2843 P1a  |  |                   | ld .<br>12. Was Dec       | adant C                | in II S  | 142 Wes              | 21222                          | i- Od-i-0        | / Casaif: Vas as N                  |                   | USA                              | an Indian Blook                               |
| Dre, MD 21215-0036 st 1 and 2 should be filed within 72 hours after death with the Maryland st Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director  |          | 1 X Never Marrie  |  |                   | Armed Fo                  | orces?                 | unk  |                      | es, specify Cubar              |                  | ( Specify Yes or Nerto Rican, etc.) | 40-               | 14. Race - Americ<br>White, etc. | can inglan, black,                            |
| ter de   |          | 3 Widowed   | 4 Div  | orced             | 1 Yes<br>f Yes, Give Yea  |                        | X No   | 1                    | Yes 2X No                      | specify:         |                                     |                   | Specify:Whit                     | e   |
| urs afterural"   |          | 15. Decedent's Ed   |  |                   | or Dates:                 |                        | oleted) 16   |                      |                                |                  | of work done                        | 16b               | . Kind of Business/Ir            |   |
| OO36 within 72 hour giene. her than "natu Exau   | 5        | Elementary/Seco   | ndary (0-12)   | Т                 | College (1                | -4 or 5+               | <del>-</del> )                                     |                      | st of working life             | DO NOT use       | retired)                            |                   |                                  |   |
| 036<br>ithin and and and and and and and and and an  | 1        | unk   | 7  |                   | -un                       | k                      |  | labor                | er                             |                  |                                     |                   |                                  |   |
| 21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica   | )        | 17. Father's Name (   | First, Middle,   | Last)             | unk                       |                        | •  |                      |                                |                  | ame (First, Middle                  |                   |                                  |   |
| 121<br>1 be fi<br>ental ]<br>arked<br>vent,  | ונ       | James E.  |  |                   |                           |                        |  |                      |                                |                  | cia <del>Leat</del>                 |                   |                                  |   |
| D 21<br>should Mund Mund Mund Mund Mund Mund Mund Mun  | -        | 19a. Informant's Na   |  |                   |                           |                        | - 4  |                      | ,                              |                  |                                     |                   | City or Town, State,             | · · · · · · · · · · · · · · · · · · ·         |
| MD and 2 sho saith and em 27 is raumati  | -        | Tracey I  |  | ord-              | Brown/                    | Si                     |  |                      | Plaintic<br>tion (Name of cer  |                  | Dundalk<br>Date                     |                   | 212221<br>Location - City or     |   |
| Ore<br>ges 1 g<br>of He<br>If it   | ľ        | 1 Burial 2  | _  | 3 🗌               | Removal fro               | om State               |  | natory or oth        |                                | ,                | 24.0                                | -**               |                                  |   |
| Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director  |          | 4 Donation 5  |  |                   |                           |                        |  | 22. N                | ame and Address                | of Facility -    | 1 (5                                |                   | D 1.1                            |   |
| Depart<br>Depart<br>Imp  | i.       | 21. Signature de FON  | 2//  | //                | U/SV                      | U                      |  | R.                   | altimore                       | Mary             | 1and 212                            | 0.1               | . Baltimo                        | re Street                                     |
| Physician  | 7        | 23a. Part I. Enter the  | e disease, or<br>v one cause   | complic           | cations that ca           | aused th               | ne death. Do                                       | not enter th         | e mode of dying,               | such as cardia   | ac or respiratory a                 | rrest, s          | hock, or heart                   | Approximate Interval<br>Between Onset and     |
| Examiner   |          | Immediate Cause (F  |  |                   |                           |                        |  |                      |                                |                  |                                     |                   |                                  | Death   |
|  | 1        | or condition resultin   | ig in death)   | Di                | ue to (or as a            | conseq                 | uence of):   |                      |                                |                  |                                     |                   |                                  |   |
| 1  | 5        | Sequentially list con<br>if any, leading to im-                 |  | b                 | ue to (or as a            | conseq                 | uence of):   |                      |                                |                  |                                     |                   |                                  |   |
| red<br>nsit<br>Examiner  |          | cause. Enter Under (Disease or injury the events resulting in o | nying Cause<br>nat initiated   | c                 | ue to (or as a            |                        |  |                      |                                |                  |                                     |                   |                                  |   |
|  |          |   |  | d                 | -                         | 11                     | 10 1   | 5 160                | 17 10 10                       | )a_b             | or AR CO                            | n3                | 5/3/10 <del>7</del> 7            |   |
| 0, be execusivities and solution and purial - tra  |          | X UNPENDED  |  |                   | AMENDED 3                 | a,2                    | 7,28a  | f,per                | MÉ g902                        | 4/27/            | 10 TT                               | 05                | 5/3/10TT                         |   |
| Box 68760, the death certificate be the attending physic and for use as the burn by sician/Med.  |          |   | /as decedent pregnant in the 1 Live high a Estal death 3 Estagrange Month Di |                   |                           |                        |  |                      |                                |                  |                                     | ay Year           |                                  |   |
| x 68<br>h cert<br>tendiir<br>use a   | 2        | past 12 months  |  |                   |                           |                        | me of death  |                      | er (Specify)                   |                  | ·9··/                               | - 1               |                                  | 9   |
| ). Box 6876 the death certificate by the attending phy ched for use as the Physician/M   |          | 1 Yes 2 N   | lo 9 Unk   | nown              | 9 Unkno                   | own                    |  |                      |                                |                  |                                     |                   |                                  |   |
| i, P.O. Box 6876 ires that the death certificate signed by the attending phy be detached for use as the lederached for use |          | Part II. Other signif   | icant condit   | ions c            | contributing to           | death l                | but not resu                                       | Iting in the ur      | nderlying cause g              | jiven in Part I. |                                     |                   | o use contribute to t            |   |
| S, P<br>uires t<br>uires t<br>d be d   |          |   |  |                   |                           |                        |  |                      |                                |                  | _                                   |                   |                                  | ably 4 🗸 Unknown                              |
| ords w requi   |          |   |  |                   |                           |                        |  |                      |                                |                  |                                     | opsy              | prior to co                      | opsy findings available ompletion of cause of |
| tal Records, cian: The law require certificate has been signer, page 2 should be Completed   |          |   |  |                   |                           |                        |  |                      |                                |                  | per<br>1 ✓ Yes                      | formed?           |                                  | s 2 No  |
| tal R<br>cian: T<br>certific<br>ector, p   | ۱,       | 25. Was case referr   | ed to medical  | T                 |                           |                        |  |                      | 26.Place                       | of Death (Che    | eck only one)                       |                   |                                  |   |
| Vita   | ١.       | examiner?<br>1 ✓ Yes 2  | 2 No   | Ho                | spital: 1 1               | npatient               | t 2 🗸 EF   | VOutpatient          | 3 DOA                          | Other Nu         | rsing Home 5                        | Resid             | dence 6 Other                    | :   |
| of Ving Physiums Physium Physi |          | 27. Manner of Death   | 1  |                   | 28a. Date<br>(Month       | of Injury<br>, Day,Yea | / 28<br>ar)  | b. Time of In        |                                | ry at Work?      | 28d. Describe                       | e how is          | njury occurred                   |   |
| ion<br>ttendi<br>tor:<br>the f   |          | 1 Natural 2 Accident  | 5 Pend   | ling<br>stigation | Fd 4/                     | 8/1                    | 0 lu   | nk                   | 1 1 1                          | res 2 X No       | unk                                 |                   |                                  |   |
| Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.  Certification: To Be Completed by P.  |          | 3 Suicide   | 6 K Coul   | d not be          | 28e Place                 |                        | iry - At home $\mathrm{nk}$                        | e, farm, stree       | t, factory, office b           | uilding, etc.    | 28f. Location<br>or Town,<br>unk    | (Street<br>State) | and Number or Rur                | al Route Number, City                         |
| y fill   | - 1 -    |   |  |                   | n: To the bes             | t of my                | knowledge,   |                      |                                |                  | and due to the ca                   | use(s) a          | and manner as state              |   |
| To the He within 24 To the Ft completel  | Į        | 2 29b. Signature and t  |  | а                 | and manner s              | tated.                 | auvii aliu/  | e. mresugati         | 29c. Licens                    |                  | os actino unite, dal                |                   | I. Date signed (Mon              |   |
| _   2  | 1        | Loo. Signature and t  |  |                   |                           |                        |  |                      | O.C.I                          |                  |                                     |                   | oril 9, 2010                     | ur, Day, rear)                                |
|  |          | 20 North  |  |                   |                           |                        | -1L (I) - A-                                       | -)                   | 1 0.0.1                        |                  |                                     | 1.,               |                                  |   |
|  |          | 30. Name and addre<br>Ana Rubio N                               |  |                   | mpleted caus<br>Medical E |                        |  |                      | treet, Baltimo                 | ore, MD 21       | 201                                 |                   |                                  |   |
| State  | ~        | 31. Date filed (Mont/   |  | 001               |                           | igistrar's             | Signature  |                      |                                | _                |                                     | •                 |                                  |   |
| Registra   |          | - Al  | PR 26  | 201               | U Ser                     | alcol.                 | - <del>                                     </del> | par                  | E.                             |                  | OOME                                |                   |                                  |   |
| DHMH 17 Rev 1/2001   | I        |   |  |                   |                           |                        | (  | DŘÍGINAL             | -                              |                  | OCME                                |                   |                                  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GOSSARD Month 40 Year 710 AM Medical 10 4a. Facility Name (if not institution, give street and number) H • 5 P 1 TH 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE WASHINGTON GLEN BURMIE ANNE AMUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 89 04706/1921 Maryland **Director** 213 12 4668 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Baltimore Anne Arundel Maryland 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4302 Cortez Road 21225 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) al Hygiene. Eastern Sales &  $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Electrician Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ (not available) Gossard Marquerite Knott other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Rosalee Gossard / Wife 4302 Cortez Road Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 04/27/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Baltimore National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Lart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ) Medical Examiner ALZHEIMENS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 - use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown been signed by the should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basic of examination and/or invanitation in a procedure of the cause of examiners and the cause of examination and the cause of examinati 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practions 2. It is a stating moving duals around dat to the cause and due to the cause(s) and manner stated. 29b. Signature and title of certifier か37111 PRAPULL PANCE, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30015. H MOVERST #108 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 24 Day 2010 Year Charlotte L. Good 8:30 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 245 Green Fern Way Lansdowne Baltimore Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 M 2 X 10/14/1927 Country) 82 Director MD 214-24-3958 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Lansdowne MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 245 Green Fern Way 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 □ Divorced If Yes, Give White Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ William Hingarner Mary Cramblit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Grimes - daughter 245 Green Fern Way Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State metery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Ardent Crematory 04/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD M0084522. Name and Address of Facility Harry H. Witzke's Family F.H.Inc Signature of Funeral Pervice Live 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between inset and De In Immediate Cause (Final AORTIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by LMONARY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 29b. Signature and title of certifi

State Registrar s of person who completed cause of death (Item 23a) (Type, Print)

10-03057 Sarah F. Grappel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mantal Hygiene

| пант. Огаррс  |                | 1- For State Registrar  | <b>187,205</b> 7, Септ                     | er flyg902 02<br>ificate of Death   | 7/26/2010th                                      | Reg.                             | No. 201                              | 0 1280  |
|---|----------------|---|--|-------------------------------------|--|----------------------------------|--------------------------------------|---|
| Physicia  | an/            | Decedent's Name (First, Middle,Last)  | 004005                                     |                                     |  | 2. Date of Death                 |                                      | 3. Time of Death                                |
| edical Exami  | ner            | SARAH F<br>4a. Facility Name (if not institution, give stree                                    | GRAPPEL                                    | dh City Town                        | , or Location of Death                           | April 19, 20                     | 4c. County of Death                  | 1700 hrs  |
|   |                | Rt. 95 South Bound S of Rt. 32  |  | Columbia                            |  |                                  | Howard                               |   |
| Funeral   |                | Social Security Number     6. Sex   | 7. Age (In yrs. las                        |                                     |  | 8. Date of Birth                 | MM/DD/YYYY) 9. Bir<br>Foreig         | thplace (State or                               |
| Director  |                | 102-32-0337 1□M   | 2X F 71                                    | Yrs. Months I                       | Days Hours Min.                                  | 01/11/2                          |                                      | untry) NY                                       |
| 'n  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, T                               | own or Location                     |  |                                  |                                      | 10d. Inside City Limits                         |
| ne Maryland<br>or 28a-f show any<br>fied at once.   | L              | FL BROWARD  | HOLI                                       | LYWOOD                              |  |                                  |                                      | 1 Yes 2 No                                      |
| farylar<br>18a-f s<br>at on   | Director       | 10e. Street and Number  | 102  | 10f. Zip Coo                        | le   | 10g                              | . Citizen of What Cou                | ntry?   |
| ith the Maryland<br>23a or 28a-f sho<br>notified at once.   | ä              | 1201 SOUTH OCEAN DE   | RIVE, #1012N                               | 33                                  | 3019   |                                  | USA                                  |   |
| th with   | Funeral        |   | Was Decedent Ever in U.S<br>Armed Forces?  |                                     | f Hispanic Origin? ( Sp<br>ıban, Mexican, Puerto |                                  | 14. Race - Ameri<br>White, etc.      | can Indian, Black,                              |
| ter dea   |                | 3 Widowed 4 X Divorced If Yes   | Yes 2 No                                   | 1  Yes 2 ▼                          | No specify:                                      |                                  | Specify: W                           | HITE  |
| ours aft<br>tural'  | d by           | 15. Decedent's Education (Specify only high   | tes:                                       | 16a. Decedent's Usual Occ           | upation (Give kind of w                          |                                  | 6b. Kind of Business/                |   |
| 6<br>72 hc<br>an "na<br>cal Ex  | Completed      | Elementary/Secondary (0-12)   | ollege (1-4 or 5+)                         | during most of working              |  | ed)                              |                                      |   |
| withir piene.   | ошо            | 17. Father's Name (First, Middle, Last)   | 5+   | RESEARCH SO                         |  | (Eiret Middle Ma                 | MEDICAL iden Surname) <b>B1u</b>     |   |
| 21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica  | Be C           | UNKNOWN GRAPPEI   | L  |                                     | PAULINE  | (r irst, ivilidale, ivia         | ELUTHAL                              | thal  |
| ID 21215-0036 should be filed within 72 hours after and Mental Hygene. 7 is marked other than "natural", c natic event, the Medical Examiner. | ٦<br>و         | 19a. Informant's Name/Relationship (Type, P   | rint )                                     | 19b. Mailing Address (S             | treet and Number or R                            | ural Route Numbe                 | er, City or Town, State              | , Zip Code)                                     |
| <b>∑</b> 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5  |                | FRANCINE SUSSMAN/S.  20a. Method of Disposition   |  | 3450 SOUTH (                        |  |                                  | PALM BEAC<br>20c. Location - City or |   |
| 2 : E : 5   |                | 1 X Burial 2 Cremation 3 X Re   | emoval from State cre                      | ematory or other place Mt.          | . Zion 05/0                                      | 03/2010                          | Maspeth                              |   |
| Baltimo<br>permit. Page<br>Department o<br>Important:   |                | 4 Donation 5 Other Specify: 21. Signature of Fluneral Service Licensee                          | MT.  | ARAT CEMETEI  22. Name and Add      |  | 2/2010                           | FARMINGDA                            |   |
| Day Derri   |                | /// INIAAN  | iger                                       |                                     | ISTERSTOWN                                       |                                  | SON & BROS<br>IKESVILLE,             |   |
| Physician   |                | 23a. Part I. Enter the disease, or complication failure. List only one cause on each line       | that caused the death. E                   | Do not enter the mode of dy         | ing, such as cardiac or                          | respiratory arrest               | , shock, or heart                    | Approximate Interval<br>Between Onset and       |
| `/Medical<br>≛xaminer   |                | P4. 4.2 . 1 . 4.3   | ple Injuries                               |                                     |  |                                  |                                      | Death   |
|   |                | b but to  | o (or as a consequence of):                |                                     |  |                                  |                                      |   |
|   | ner            | Sequentially list conditions, if any, leading to immediate Due to cause. Enter Underlying Cause | (or as a consequence of):                  |                                     |  |                                  |                                      |   |
| _   | Examiner       | (Disease or injury that initiated C   | (or as a consequence of):                  |                                     |  |                                  |                                      |   |
| executed<br>an and<br>al - transi   | a<br>E         | d   |  |                                     |  |                                  | · <del>_</del> · · · · · · ·         |   |
| ox 68760,<br>ant certificate be executed<br>attending physician and<br>for use as the burial - transit  | edic           |   | ENDED                                      |                                     |  |                                  | •                                    |   |
| 30x 68760, death certificate be attending physici   | W/u            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?                                    | . If yes, outcome of pregna<br>Live birth  | ancy<br>2 Fetal death               | 3 Ectopic pregnar                                | псу                              | 23d. Date of delivery  Month         | /<br>Day Year                                   |
| Box 687 death certific the attending p  | Physician/     | 1 Vos 3 No 9 Uskrous  | Pregnant at time of deat                   |                                     |  |                                  |                                      |   |
| G the G W   | Phy            | 9   | Unknown                                    | ulting in the underlying cau        | se given in Part I.                              | 23e. Did toba                    | cco use contribute to                | the cause of death?                             |
| P.O.  | d b            |   |  |                                     |  | 1 Yes                            | 2 No 3 Prot                          | oably 4 🗹 Unknown                               |
| cords,<br>law required has been so  | ete            |   |  |                                     |  | 24a. Was an<br>autopsy           |                                      | topsy findings available completion of cause of |
| Reco<br>The law<br>icate has  | Completed      |   |  |                                     |  | performe                         | ed? death?                           |   |
| tal Recicion: The certificate   | Be C           | 25. Was case referred to medical examiner?  | · ·  | 26.P                                | lace of Death (Check of                          |                                  |                                      |   |
| Sir ysi   | To E           | 1 ✓ Yes 2 No  | I Inpatient 2 C                            | R/Outpatient 3 DOA                  |  |                                  | esidence 6 🗸 Other                   | Scene   |
| ion of<br>tending Ph<br>eath.<br>for: After<br>the funeral  | ion:           |   | (Month Day Year)                           | 28b. Time of Injury 28c. 0000 hrs 1 | Ves 2 No   | •                                | of vehicle involv                    | ed in motor                                     |
| risic<br>r Atter<br>rer dea<br>irector  | ficat          | 2 Accident Investigation  | 8e. Place of Injury - At hon               | ne, farm, street, factory, offic    |  |                                  | eet and Number or Ru                 | ral Route Number, City                          |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director:   | Certification: |   | (Specify) Major Road                       | / Highway                           | F  | or Town, Stat<br>RT. 95 South Bo | e)<br>ound S. of Rt. 32, S           | avage, MD                                       |
| re Hos<br>n 24 ho<br>re Fun<br>letely i   |                | Contour only  |  | e, death occurred at the time       |  |                                  | •                                    |   |
| To the within To the comple   | Medical        |   | ne basis of examination and manner_stated. | d/or investigation, in my opin      | nion, death occurred at                          |                                  | d place, and due to the              |   |
|   | =              | III III   | - 7  |                                     | C.M.E. OGM                                       | _                                | April 20, 2010                       | , var, (6at)                                    |
| 10 /  |                | 30. Name and address of person who complete   | eteclosuse of death (Item 2                | ul.                                 |  |                                  |                                      |   |
| DV  |                | Theodore M. King, Jr., MD.  | Assistant Medical Ex                       |                                     | Street, Baltimore                                | , MD 21201                       |                                      |   |
| St  | ate            | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signature                  | 1-001                               |  |                                  |                                      |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ 240 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 850 A West Street Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** DC Country) 1 M 2 - F Hours 0173071958 52 214-76-9426 Director Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Anne Arundel Annapolis 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 850 A West Street 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) econday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Geneieve E. Stride Bonsal Goodrich, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Wright / Sister 6666 Wilson Rd. Friendship, MD 20758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory 4 Donation 5 Other (Specify) 04/22/2010 Hanover, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility 7522 Connelley Dr. #N Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No 9 Unknown Records, P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Des 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The this certificate I 1 Yes 2 No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 200 Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one 29b. Signatu 29d. Date signed (Month, Day Year) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

|   |                |  | rieas                      |                           |                                 |                                  |                               |                           |                          |   |                         | Copies                                |                         | _eg                | DIE.                     |   |
|---|----------------|--|----------------------------|---------------------------|---------------------------------|----------------------------------|-------------------------------|---------------------------|--------------------------|---|-------------------------|---------------------------------------|-------------------------|--------------------|--------------------------|---|
|   |                | For State  |                            | Stat                      | e of Ma                         | ryland                           |                               |                           |                          |   | and M                   | ental Hy                              |                         | 0.0                | 10                       | 10000   |
|   |                | Registrar  |                            |                           |                                 |                                  | Cel                           | tificat                   | e ot L                   | Jeath   |                         |                                       | Reg. No.                |                    | 1 U                      | 12000   |
| Physicia  | an             | 1. Decedent's Name (Fi   |                            |                           |                                 | НА                               | SLUP                          |                           |                          |   |                         | 2. Date of De<br>Month                | ath<br>Day              | 10                 | Year                     | 3. Time of Death                              |
| /Medic  |                | Stepha   |                            | Ann                       | •                               | ( ) / )                          | 2011                          |                           | _                        |   |                         | -                                     |                         | 17                 | 2010                     | 8:53 PM                                       |
| Examine   | er             | 4a. Facility Name (If not  |                            |                           |                                 |                                  |                               | 4b. City,                 |                          | Location o  |                         |                                       | 4c.                     | County             | of Death                 |   |
| pr.   |                | HARBO  |                            | . Sex                     |                                 | (In ura la                       | act hirth day                 | If Under                  |                          | TIM (   |                         | CITY<br>8 Date of Bir                 | th                      |                    | 0 Riethr                 | lana (State or Femige                         |
| Funeral   |                | 5. Social Security Numb<br>214-78-13   | 06 6                       | 1 ☐ M 2 ☐                 | X⊊ 7.Age                        | 5                                | st birthday)<br>Yrs.          | Months                    | Days                     | Hours   | Min.                    | 8. Date of Bir<br>(Month, Da<br>10/28 | y Year)                 |                    | Gour                     | place (State or Foreign htry)  MD             |
| Director  |                | Usual Residence of Dec   | edent                      |                           |                                 |                                  |                               |                           |                          |   |                         | 10/20                                 | 7 30                    | -                  | L                        | 110   |
| yland<br>Now  |                |  | b. County                  | NT / 7                    |                                 | 10c. City                        | Town or Lo                    | cation                    | - 7.4-2.                 |   | a: 1                    |                                       |                         |                    | 1                        | 0d. Inside City Limits                        |
| Mar.  | 햦              | MD   |                            | N/A                       |                                 |                                  |                               | В                         | artı                     | more  | City                    |                                       |                         |                    |                          | 1 X Yes 2 ☐ No                                |
| h the   | Director       | 10e. Street and Number   |                            |                           |                                 |                                  |                               | 10f. Zip                  | Code                     |   |                         |                                       | 10g. Citi               | zen of             | What Cour                | ntry?   |
| h wit   | aD             |  | 1546                       | South                     | Hanov                           | ær S                             | treet                         |                           | 21                       | 230   |                         |                                       |                         | USP                | A                        |   |
| dea   | Funeral        | 11. Marital Status   |                            | 12. Was                   | Decedent E                      | ver in U.S                       | 3. 13.                        | Vas Deced                 | dent of Hi               | ispanic Ori   | gin? (Spe               | ecify Yes or No<br>Rican, etc.)       | )-                      |                    | ce - Americ              |   |
| after<br>or ite   | J.             | 1 Never Married  | 2 Marrie                   | d 1 🗆 '                   | Yes 2200<br>s, Give             | 0                                |                               | Yes                       |                          | Specify:  |                         | riicari, etc.)                        |                         |                    |                          | White   |
| ours<br>iral",  | d b            | 3XXWidowed 4 □   | Divorced                   | Year                      | or Dates:                       |                                  |                               |                           | 420                      | ороолу.   |                         |                                       |                         | Specif             | y.<br>                   |   |
| 72 h  | ete            | 15.<br>(Specify o  | Decedent's<br>only highest | Education<br>grade comple | eted)                           |                                  | 16a. Deced<br>(Give           | lent's Usua<br>kind of wo | al Occupa<br>rk done d   | ation<br><i>during m</i> osi<br>/)  | t of workir             | ng                                    | 16b. Kii                | nd of B            | usiness/In               | dustry  |
| within sne.   | Completed      | Elementary/Secondar  | y (0-12)                   | Colle                     | ege (1-4or 5+                   | -)                               |                               |                           |                          | ,<br>erato  |                         |                                       |                         | N                  | /anufa                   | acturing                                      |
| iled v<br>Hygie<br>ther i   |                | 17. Father's Name (First   |                            | ect)                      | 0                               |                                  |                               |                           |                          |   |                         | (First, Middle                        | Maiden                  | Surnar             | me l                     |   |
| l be f<br>ed ol   | Be             | Cha  | rles                       | E. Ev                     | ans                             |                                  |                               |                           |                          | L INIOUNE   | olor                    | es V.                                 | Naun                    |                    |                          |   |
| hould Me mark   | ပ္             | 19a. Informant's Name/   | /Relationshir              | /Type Print               |                                 |                                  | 10b Mailin                    | a Addroon                 | (Stroot                  | and Numbe   | ar or Pum               | l Route Numb                          | or City o               | r To wn            | State 7ir                | Codol   |
| d 2 s<br>th ar<br>th ar<br>trau   |                | Charle   |                            |                           |                                 | n                                |                               |                           |                          |   |                         | altimo                                |                         |                    |                          | Code)   |
| Hea tem   |                | 20a. Method of Disposit  | tion                       |                           |                                 | 20b. Pl                          | ace of Dispo                  | sition (Nar               | ne of                    |   | D                       | ate                                   | 20c. Lo                 | cation             | - City or To             | own, State                                    |
| ages<br>ent of<br>tt: #f  |                | 1 Burial 2XXCr   |                            |                           | from State                      | ce                               | Arden                         | atory or o                | mato                     | ry  | 4/24                    | /2010                                 | Hand                    | vei                | Mar                      | yland   |
| ortan   |                | 4 ☐ Donation 5 ☐<br>21. Signature of Funera                                  |                            |                           | tor D                           |                                  |                               |                           |                          | i   |                         |                                       |                         | U.S.               |                          |   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutified at once. |                |  |                            | S )                       | .tor 1.                         |                                  |                               | narle<br>501 E            | s L.                     | "Stev<br>Fort   | ens<br>Aven             | Funera<br>ue, Ba                      | l Hor<br>Ltimo          | ne,<br>ore         | Inc.                     | 1230  |
|   |                | 23a. Part 1. Enter the di  | isease, or co              | omplications              | that caused                     | the death                        |                               |                           |                          |   |                         |                                       |                         |                    |                          | Approximate                                   |
| Dhysisian   |                | shock, or heart fai<br>Immediate Cause (Fina                                 |                            |                           |                                 |                                  |                               |                           |                          |   |                         |                                       |                         |                    |                          | Interval Between<br>Onset and Death           |
| Physician<br>/Medical   |                | disease or condition<br>resulting in death)                                  |                            |                           | ARD L                           |                                  |                               | ST                        |                          |   |                         |                                       |                         |                    |                          |   |
| Examiner  |                |  |                            |                           | de to (or as a                  | consequ                          | erice or).                    |                           |                          |   |                         |                                       |                         |                    |                          |   |
| *   | je             | Sequentially list condition if any, leading to immed cause. Enter Underlying | ons,<br>liate              | b                         | ue to (or as a                  | consequ                          | ence of):                     |                           |                          |   |                         |                                       |                         |                    |                          |   |
| be executed<br>cian and<br>ourial-transit   | Examiner       | Cause. Enter Underlying<br>Cause (Disease or injurthat initiated events      | g<br>Y                     |                           |                                 |                                  |                               |                           |                          |   |                         |                                       |                         |                    |                          |   |
| an an rial-tr   |                | resulting in death) Last   | - 1                        | D.                        | ue to (or as a                  | consequ                          | ence of):                     |                           |                          |   |                         |                                       |                         |                    |                          |   |
|   | ical           |  |                            | d                         |                                 |                                  |                               |                           |                          |   |                         |                                       |                         |                    |                          |   |
| The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the   | Physician/Medi | IF FEMALE:   |                            |                           |                                 |                                  |                               |                           |                          |   |                         |                                       |                         |                    |                          |   |
| th ce<br>tendi<br>r use   | an/l           | 23b. Was decedent pre-   |                            |                           | s, outcome of                   |                                  |                               | Ectopic p                 | regnancy                 | v   |                         |                                       | :                       |                    | ate of deliv             | •   |
| e dea   | sici           | in the past 12 mon<br>1 ☐ Yes 2 ☑ No   |                            | 4 🗆                       | Pregnant at<br>Unknown          |                                  |                               | Other (sp                 |                          | ,   |                         |                                       |                         | M                  | onth                     | Day Year                                      |
| that the de   | ڳ              | 9 ☐ Unknown  |                            |                           |                                 |                                  |                               |                           |                          |   |                         |                                       |                         |                    |                          |   |
| res th  | þ              | Part II. Other significan  |                            |                           |                                 | t not resu                       | Iting in the ui               | nderlying c               | ause give                | en in Part I  | •                       |                                       |                         |                    | ,                        | he cause of death?                            |
| w requir<br>been s<br>should  | ted            | ANOXIC   | BRAI                       | N IN                      | JURT                            |                                  |                               |                           |                          |   |                         | 1 📗                                   | Yes 2[                  | ∐ No               | 3 Pro                    | bably 4 Unknown                               |
| law ras b   | Completed      | ACUTE  | RESS                       | PIRAT                     | ORY F                           | AILL                             | IRE                           |                           |                          |   |                         | 24a. Was                              |                         | 24b.               | Were auto                | opsy findings available ompletion of cause of |
| The cate har page   | FO.            | DIABETI  | c KE                       | ETOAC                     | 12001                           | 2                                |                               |                           |                          |   |                         | perfo<br>1 ☐ Yes                      | ormed?<br>2 ☑ No        |                    | death?<br>1 ☐ Yes        |   |
| Attending Physician: The r death. ector: After this certificate by the funeral director, page   | Be (           | 25. Was case referred t examiner?  |                            |                           |                                 |                                  |                               |                           |                          | 26. Place   | of Death                | (Check only                           | one)                    |                    |                          |   |
| Physic<br>this c  | မ              | 1 ☐ Yes 2 ☑ No   |                            | Hospital:                 | 1 Inpatier                      | nt 2 🗆 E                         | ER/Outpatier                  | t 3 □ D0                  | OA Othe                  | er:<br>4□ Nu  | ursing Ho               | me 5 ☐ Res                            | idence                  | 6 □Ot              | her (Speci               | fy)   |
| ding P.<br>h.<br>After 1<br>funera  | on:            | 27. Manner of Death<br>1 Natural 5   | Pending                    | 28a.                      | Date of Injur<br>(Month, Day)   | y<br>; Year)                     | 28b. Time of<br>Injury        | 2                         | 28c. Injury<br>Work      | y at<br></td <td>4</td> <td>28d. Describe</td> <td>how injur</td> <td>y occu</td> <td>rred</td> <td></td> | 4                       | 28d. Describe                         | how injur               | y occu             | rred                     |   |
| eath.   | cati           | 2 Accident   | investigat                 | t ho                      |                                 |                                  |                               | М                         |                          | Yes 2   | No                      |                                       |                         |                    |                          |   |
| or At<br>fiter d<br>virect<br>n by  | Certification: | 3 ☐ Suicide 6<br>4 ☐ Homicide  | determin                   | ed 28e.                   | Place of Inju<br>building, etc. | ry - At hoi<br>. <i>(Specify</i> | me, farm, str                 | eet, factory              | , office                 |   | 1                       | 28f. Location (<br>City or To         | Street an<br>wn, State  | d Num<br>)         | ber or Run               | al Route Number,                              |
| urs a   |                |  |                            |                           |                                 |                                  |                               |                           |                          |   |                         |                                       |                         |                    |                          |   |
| To the Hospital or Attendin<br>within 24 hours after death<br>To the Funeral Director: Aff<br>completely filled in by the fun   | Medical        | 29a. Certifier 1 ☑ (Check only 2 ☐ one)                                      | Certifying Medical Ex      | caminer: On               | the basis of                    | examinat                         | vledge, deat<br>ion and/or in | n occurred<br>vestigatior | at the tir<br>n, in my o | me, date ar<br>pinion, dea  | nd place,<br>ath occurr | and due to the<br>ed at the time      | e cause(s<br>, date and | ) and r<br>I place | nanner as<br>, and due t | stated.<br>o the cause(s)                     |
| the ithin the omple   | Mec            | 29b. Signature and title   | of certifier               | and                       | I manner stat                   | teg.                             |                               | 290                       | License                  | e number  |                         |                                       | 29d Da                  | e sign             | ed (Month.               | Day, Year)                                    |
| <b>5</b> ≥ 5 8  |                | 200. Oignature and little  | or certifier               | 1                         |                                 |                                  |                               |                           |                          |   | 4                       |                                       |                         |                    |                          | bay, Tour,                                    |
|   |                | 00 N ==  |                            |                           |                                 | NEK                              |                               |                           | KE                       | 500   | 1                       |                                       |                         | 11,                | 1/10                     |   |
| 10  |                | 30. Name and address of ANG KO,  |                            |                           |                                 |                                  |                               |                           | 105                      | MA  | 2120                    | 7                                     |                         |                    |                          |   |
| Ct-   | to             |  |                            |                           |                                 |                                  |                               |                           |                          | MU  | 4166                    | - 3                                   |                         |                    |                          |   |
| Stat<br>Registra  |                | A F  | າກ ຄ <i>າ</i>              | 2010                      | gistra.                         | Jorginal                         | 1 1                           | arka                      | 1                        |   |                         |                                       |                         |                    |                          |   |
| OHMH 17 Rev 1/20  |                | At   | "K & O                     | 2010                      | peru                            |                                  | 17                            | क्षण पर                   |                          |   |                         |                                       |                         |                    |                          |   |
|   |                |  |                            |                           |                                 |                                  |                               |                           |                          |   |                         |                                       |                         |                    |                          |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Marley Neck Health & Rehab. Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🕱 F 86 Director 218 18 4963 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Exeminant must be notified at Maryland Funeral Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 7575 E. Howard Road 21061 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 1 ∐Yes 2 X No 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2K No Yes. Give Specify ģ 3 Nidowed 4 Divorced Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) Charles A. Runge Dora Shirley ပ္ 19a. Informant's Name/Relationship (Type. Print) Frederick Harris / Son 1204 Seven Oaks Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If It eny Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licensee ramerous 23a. Fart 1. Enter the dis user in complications that caused the shock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any least in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consultation of To the Hospital or Attending Physician: The law requires that the deeth cerificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an autopsy performed 1 □ Yes 2**;**Z∕No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? ₩ Natural 5 Pending within 24 hours after death. To the Funeral Director: A neral Director: A investigation 1 ☐ Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier Medical and manner stated. 29b. Signature and title

1. Decedent's Name (First, Middle, Last)

Month **Physician** Day 21 Year Doris R. Harris April 2010 8:21 P. 4c. County of Death Anne Arundel 2/15/1924. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian Black, White, etc. Specify. White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Halethorpe, Maryland 21227 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) person who completed cause of death (Item 23a) (Type, Print) 31. Date filed Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh g903 5/7/10 TT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year 2:45 P M April Margaret Louise Hahn 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛣 F Months 218-09-7280 95 Dec. 1914 Director 26. Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. 10a. State 10c. City, Town or Location 10d, Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 □ No Carroll Maryland Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Lehigh Dr. Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify ρ 3 Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) department supervisor 9 retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Lee Flickinger ပ Grace Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Donna Green/ niece 11318 Green Valley Rd. Union Bridge, MD 21791 permit. Pages 1 and Di partment of Healt Important: If item 2 any Injury or other Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Luth. Cem. 4/24/2010 Uniontown, MD 21. Signature of Fune al Service Licens 22. Name and Address of Facility Hartzler Funeral Home attarine ( 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6 E. Broadway Union Bridge, MD 21791 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 hr. disease or condition resulting in death) Acute myocardial infarction /Medical Due to (or as a consequence of): Examiner 15 yrs. Hypertension Sequentially list conditions, Examiner any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 X No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 **X**No 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, After

eral Director: A within 24 hours a

To the Funeral C

completely filled

Be Certification: To

Medical

State Registrar

John Lehigh

5 Pending investigation

6 ☐ Could not be

determined

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No

27 Manner of Death

1 Naturai

3 ☐ Suicide

29a. Certifie

4 Homicide

2 Accident

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

29c. License number D0020330

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 4/22/10

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

and manner stated

104 N. Main St.

Union Bridge, MD 21791

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Date filed (Month, Day, Year, 32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 23 **Physician** 2010 Helen Elizabeth Hood April 5:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Brinton Woods Nursing & Rehab. Ctr. Winfield Carroll 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🔀 F Months 96 Director 218-40-3554 16, 1914 Virginia Jan. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Carroll Mt. Airy 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 201 E. Church St. 21771 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' iry or other traumatic event, the "Mo Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker/ nursing assistant own home/ hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( George Reynolds ပ Gertrude Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald W. Hood/ son 201 E. Church St. Mt. Airy, MD 21771 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2010 Prospect Cemetery Mt. Airy, MD 21. Sin Jure o Funeral Service Dicensee/ 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mulau /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) attending physician Physician/Medical the SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.O. the detached 9 I Inknown 9 Unknown à signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 2 No of Vital 1 ☐ Yes 25. Was case referre on medical examiner? the funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yeş 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: 6 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one)\_ within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 30. Nerve an address of person who completed cause of death (Item 23a) (Type, Print) 1000 LIBORTY RD ELDTRSBURG NO 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Ida Johnson 11:25P 2010 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care of Canton Harbor Baltimore 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🛱 F Director 83 213-34-1357 South Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Mindfeal Examination 200.000. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 N. Washington Street, #402 21231 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Food & Beverage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Simmie McBride Ida Bell Alford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 N. Washington St., #409, Baltimore, MD 21231 Hattie Bostic / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ⊠Donation 5 ☐ Other (Specify) Anatamy Gifts Registry 04/22/2010 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Cervical **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) MSRajapahre M.D D0057465 2835 Smith Avenue, S. 203, Baltimore, MD z1209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IV N-S. Rajapakse, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City 76wn, or Location of Death **Examiner** 4c. County of Death If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State of Foreign Country) **Funeral** 1 M 2 Months (Month, Day, Year, **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City fown or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Examiner þ 1 Never Married 2 Married Yes 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Novorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed (Give kind of work done during most of life. DO NOT use retired) I Hygiene. College 1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle 18. ner's Name (First, Middle, Maid mant's Name/Relationship (Type, Print) Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery) crematory or other 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗗 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 A Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Street NAREM 501 Dol 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <at RRN 20 /4M NS 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death zabeth MYSING ent timore a . Age (In vrs. last birthday) 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Country) Virginia 1 □ M 2 🕱 F Months Days Hours 06-27-1918 217-40-5910 Director Yrs Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21043 United States 5632 Montgomery Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. 3x Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Morris Frances Knight permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Oakdale Road, Linthicum Heights, MD 21090 Eugene Jenkins - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place Meadowridge Mem. Pk. 04-23-2010 4 Donation 5 Other (Specify) Elkridge, Maryland Sign ture of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 10. Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final anemia Onset and Death Physician vere 170 disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 W No Pregnant at time of death 5 Other (specify) Month Day Year ☐ Pregnam
☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by en SI 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown adder cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ※ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 5 2010 30. Name and address of person who completed cays of death (Item 23a) (Type, Print) altimore 0 venue 2122

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) APR 26 2010

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month KERNS Physician PRIC 3:28 PM 13 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Mt. Airy Kline Hospice House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 23, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 F 1939 Pennsylvania 219-36-3973 70 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment up to nother traumatic 1 ☐ Yes 2 No Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21740 100 S. Valley Dr. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Specify. White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) administration university administration 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nedra Eleanor Downey James Earl Wright ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 100 S. Valley Dr.; Hagerstown, Maryland 21740 Ronald Kerns/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Board; 655 W. Baltimore Street 21. Signature of Funeral Service L icensee Wad Baltimore, Maryland 21201 Approximate Interval Between Onset and Death 23a. Part 1 shock Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. BLAID AND BONC Immediate Cause (Final BRENIT **Physician** ANCER 10 GEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No P.0 9 Unknown 9 Unknown neral urector; After this certificate has been signed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 □ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) KUNE Hospital: Other: HER PICE 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 310011 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. DIRECTUR 29d. Date signed (Month, Day, Year) 4601811-29b. Signature and title of certifier 29c. License number 10587 DIRECTOR HOSPICE hedica-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 FREDERICK JA. 4.0 TRAIL UERRGE. 32. R gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 DORSEY 150 AM ELIZA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 4 Year) 934 Months Days Hours 220-28-8095 75 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Sykesville Carroll 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21784 501 Oklahoma Avenue hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) education educator other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sarah Norris James Clifton Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $P.O.\ Box\ 1254$ ,  $Westminster,\ MD\ 21158$ 19a. Informant's Name/Relationship (Type, Print) Karen Byrd (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4-23-10 Sykesville, MD St. Luke UMC Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Haight P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition resulting in death) Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a and I-transit Exami To the Hospital or Attending Physician. The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 1 ☐ Yes 24☐ 9 ☐ Unknown the 9 Unknown cate has been signed by a page 2 should be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 thinknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate h
completed filled in by the funeral director, page 2 No 1 Yes Yes 2 1 Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 2 100 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 2010 nd address of person who completed sause of death (Item 23a) (Type, Print) 10 V 447, East Main st. osach 40 32. Registrar Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per loc 2902 4-26-10 years and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Janet Wenner Legro Month 4/1/2010 Physician/ 11:50anM Medical 4a. Facility Name (if not institution, give street and number)
1331 Bolton Street Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A City Birthplace (State or Foreign Country)
 NY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Social Security Number 127–18–2453 1 🗆 M 2 🔀 F (Month, Day, Year) 6/27/1926 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director NY Oneida New Hartford 1 Yes XX No 10e. Street and Number 26 Pearl Street 10f. Zip Code 10g. Citizen of What Country? 13413 UŚA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify white Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) Frank H. Wenner, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Rose Siegenthaler permit. Page 1 and 2 should be file Department of Health and Mental P Important: If item 27 is marked o any injuy or other traumatic evenores. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Bolton Street, Baltimore MD 21217 19a. Informant's Name/Relationship (Type, Print) Bonnie Legro / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Kirkland, Signature of Euneral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, Baltimore MD 21230 Jiu) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con uence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month 5 Other (specify) Pregnant at time of death the g Unknown Division of Vital Records, P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? daughter's မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 3 Name Nursing Home 6 K Other (Special 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural residence 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 only one) and title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print ALLES 0

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Eddie Wilson Lewis 20 ໃດ 12:00 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** 2410 Marbourne Avenue Apt. 3B Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. West Virginia 75 233 50 3244 1034 Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at with the Maryland Director 28a-f 1 Yes 2 No N/A Baltimore 3 4 1 Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral U.S.A. 21230 2410 Marbourne Avenue Apt. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 If Yes, Give Completed by 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Noivorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Medic U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eddie Lewis Ruth (not available) and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Ruth Ann Morgan / Daughter 2410 Marbourne Avenue Apt. 3B Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 04/28/2010 Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 namerous 4001 Ritchie Highway Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failute. List only one cause on each line. 26a. Part 1. Enter the disea Approximate Interval Between Onset and Death Immediate Cause (Final Prosician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list condulons, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transî that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IE EEMALE nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for ( Month Day Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been significated to spage 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes completed filled in by the funeral director, Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 Yes 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Accider 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) J. Kan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINTHICUM W. NA

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Morith, Day, Year)

202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death A Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if no institution, give street and number) 4b. City, Town, or Location of Death County of Examiner 40 theath P 7. Age (In yrs. If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral M 2 D F Director iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No MOI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No liftes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: and Mental Hygiene. Is marked other than "natural", 3 Widowed 4 Divorced Specify: Completed other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle ပ Department of Health and Ments Important: If item 27 is marked any injury or any injur be 19a. Informant's Name/Relationship (Type, Print) mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory 4 Donation 5 Other (Specify) 50n P. Name and Address of Facility nature of Fur eral Service Lic / ee 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Pnysician/ disease or condition mo Medical resulting in death) Examiner Sequentially list conditions, it any heading to in moder cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami bunial-transit Due to (or as a consequence resulting in death) Last signed by the attending physician the detached for use as the bunal Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 E FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year Pregnant at time of death 2 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 | No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) nper of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🔲 Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 🔲 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 WMG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Per Phy G910 12/02/10 JH and Mental Hygiene

|                     |   | 1               | For State Registrar  | ate of Maryland / Di   | Certificate of D   |  |  | Reg. No. ? ()   | 12820  |  |  |  |  |  |
|---------------------|---|-----------------|--|--|--|--|--|---|--|--|--|--|--|--|
|                     | Physicia  | n/              | 1. Decedent's Name (First, Middle, Last)  Mabel Lewis  |  |  |  | 2 Date of Dea<br><b>Apr</b> il I<br>March  | Day 2010  | 3. Time of Death  1:35 P M                       |  |  |  |  |  |
|                     | Medic<br>Examin   |                 | 4a. Facility Name (if not institution, give street a   | and number)  | 4b. City, Town, or LaPlata   |  |  | 4c. County of Deatl                                   | h  |  |  |  |  |  |
|                     | Funeral<br>Director   |                 | 5. Social Security Number 257–20–1021 6. Sex   | 7. Age (In yrs. last birtho  |  | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth<br>(Month, Day,<br>10-22- | Q Birt  | hplace (State or Foreign<br>untry)<br>lie, GA    |  |  |  |  |  |
|                     | aryland<br>ia-f show<br>ified at  | - 1             | Usual Residence of Decedent  | 10c. City, Town o  |  |  |  |   | 10d. Inside City Limits 1 ☐ Yes 2 🕅 No           |  |  |  |  |  |
|                     | ith the M<br>3a or 28<br>it be not  |                 | 10e. Street and Number   |  | 10f. Zip Code 20646  |  |  | 10g. Citizen of What Co                               |  |  |  |  |  |  |
| 980                 | is filed within 72 hours after death with the Maryland tal Hyglene.  ad other than "natural", or items 23a or 28a-f show ed out, the Medical Examiner must be notified at.  | by F            | 1 Never Married 2 Married 1  | as Decedent Ever in U.S. med Forces?  Yes 2 N No Yes, Give ear or Dates.                                   | 13. Was Decedent of His If Yes, specify Cubar  | n, Mexican, Puerto                           | cify Yes or No-                            | 14. Race - Ame<br>Black, White<br>Specify: <b>B1</b>  | rican Indian,<br>e, etc.                         |  |  |  |  |  |
| Maryland 21215-0036 | within 72 hou<br>rgiene.<br>ner than "natu<br>t, the Medical  | Completed       | 15. Decedent's Education (Specify only highest grade continuous Elementary/Seconday (0-12)   | mpleted) ((  | Decedent's Usual Occupa<br>Give kind of work done di<br>ife. DO NOT use retired)<br>otographer | ation<br>uring most of work                  | ing  | 16b. Kind of Business Federal Go                      |  |  |  |  |  |  |
| nd 2                | be filed wi<br>ental Hygic<br>ked other<br>ic event, tl   | a l             | 17. Father's Name (First, Middle, Last)  |  |  | 18. Mother's Nam                             |  |   | _  |  |  |  |  |  |
| laryla              | 12 should be file<br>alth and Mental I<br>27 is marked o<br>r traumatic eve   |                 | Lester Lewis  19a. Informant's Name/Relationship (Type, Pr   |  | Mailing Address (Street a  | nd Number or Rura                            |  | , City or Town, State, Zi                             | o Code)  |  |  |  |  |  |
|                     |   |                 | Tilda Foster (Daught  20a. Method of Disposition  1 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)   | 20b. Place of l  | 02 24th Ave  | e)   | Date                                       | MD 20748  20c. Location - City or                     |  |  |  |  |  |  |
| Baltimore,          | permit. Page 1 and 3<br>Department of Healt<br>Important: If item 2<br>any injury or other<br>once,   |                 | Brentwood,<br>In Funeral<br>twood, MD  | Home<br>20722  |  |  |  |   |  |  |  |  |  |  |
|                     | enysician/  | 3 1             | 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Conset and Death disease or condition  Congestive heart failure |  |  |  |  |   |  |  |  |  |  |  |
|                     | Medical<br>Examiner   |                 | resulting in death)  | Due to (or as a consequence of Pulmonary eden  | f):  |  |  |   |  |  |  |  |  |  |
|                     | ed  | miner           | Sequentially list conditions, if an early primer cause. Enter Underlying Cause (Disease or linjury   | Due to or as a consequence of  |  |  |  |   |  |  |  |  |  |  |
| 0                   | sate be executed<br>physician and<br>the burial-transit   | edical Examiner | that initiated events resulting in death) Last   | Due to (or as a consequence of   | n):  |  |  |   |  |  |  |  |  |  |
| 68760               | eath certificate<br>attending phy:<br>I for use as the  |                 | IF FEMALE: 23c. I  | ives, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death  | 0.0.5  |  |  | 23d. Date of de                                       | elivery  |  |  |  |  |  |
| . Box               | that the death  | Physician/M     | In the past 12 thoritis?   | Pregnant at time of death Unknown  | 5 Other (specify)  |  |  | Month   | Day Year   |  |  |  |  |  |
| ls, P.O.            | uires that the signed by the signed by the deta   |                 | Part II. Other significant conditions contribu   | ating to death but not resulting in  | n the underlying cause giv   | ven in Part I.                               |  | obacco use contribute to<br>Yes 2X No 3 🗆 F           | o the cause of death?  Probably 4  Unknown       |  |  |  |  |  |
| Records,            | or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit | Completed by    |  |  |  |  | 24a. Was<br>autor<br>perfo<br>1  Yes       | psy prior to<br>ormed? death?                         | utopsy findings available completion of cause of |  |  |  |  |  |
| /ital               | sician:<br>certificalirector,   | To Be (         | 25. Was case referred to medical examiner?  1  Yes 2 No Hospi  | tal:<br>1  Inpatient 2  ER/Out   | Oth  | er: 4X Nursing H                             |  | dence 6 🗆 Other (Spe                                  | cify)  |  |  |  |  |  |
| Division of Vital   | To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page   |                 | 1 X Natural 5 ☐ Pending 2 ☐ AccidentInvestigation  | 8a. Date of injury 28b. T  | ime of 28c. Injury   | y at   |  | now injury occurred                                   |  |  |  |  |  |  |
| Divisio             | al or Atte<br>s after de:<br>al Directo   | Certificate:    | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 8e. Place of Injury - At home, far building, etc. (Specify)  | m, street, factory, office   |  | 28f. Location (\$<br>City or Tov           | Street and Number or Re<br>vn, State)                 | ural Route Number,                               |  |  |  |  |  |
|                     | To the Hospital within 24 hours of the Funeral I completed filled   | Medical         | (Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra   | : To the best of my knowledge, on<br>the basis of examination and/or<br>actioner: To the best of my knowle | r investigation, in my opinion<br>edge, death occurred at the                                  | on, death occurred a<br>e time, date and pla | at the time, date a                        | and place, and due to the<br>ne cause(s) and manner a | s stated.  |  |  |  |  |  |
| 4                   | To t  |                 | 29b. Signature and title of certifier  | t PHYSICA  |  |  |  | 29d. Date signed (Mon<br>4/23/201                     |  |  |  |  |  |  |
|                     | 31  |                 | 30. Name and address of person who compl William J. Crittend   | den, MD 7350   | Type, Print)<br>Van Dusen R  | D # 350                                      | Laurel                                     | , MD 20707  |  |  |  |  |  |  |
|                     | Sta<br>Registi  |                 | 31. Date filed (Month, Day) 26 20  | 32. Registrar's Signature  | base   |  |  |   |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 25 per me g918 8-3-11 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Albertha **Physician** 0137 40ri 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) Funeral 220-40-9618 Months Days outh Carolina 1 M 2 M Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 es 2 No Director 10e. Street and Number 10g. Citizen of What Country? 6 262 items 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If frem 27 is marked other them any injury or other traumments. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 40 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Warried 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Completed by Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Eather's Name (First, Middle, Last 18. Mother's Name (First, Middle Be ပ 19b. Mailing Address (Street and Number or Rural Route Number 40 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Durial 2 Cremation 3 Removal from State altimore, 4 Donation 5 Other (Specify) ature of Funeral Service License 22. Name and Address of Facility MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or response Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-tran Due to (or as a consequence of) the attending physician Box 68760, Physician/Medical death certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day ō Month Year 5 Other (specify) should be detached P.O. 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 3 Probably 2 No 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed 2 No this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner' Other: 4 Nursing Home 5 Residence Hospital 1 Inpatient 1 X Yes 2 ER/Outpatient 3 🗌 DOA 6 Other (Specify) မ completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: I or Attending F after death. After 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗀 No 2 Accident Director 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Brown 600 North Wolfe St, Baltimore, MD, 21287 .orrel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay 2010 Physician/ April 22 5:40 P M Betty June Lyston Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 281-28-6896 79 Kentucky Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Middle River Maryland 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2210 Coralthorn Road 21220 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1951þ 1 Never Married 2 Married 1XXYes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 1954 Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev one. 2 Joe Walter Hennessee Allie Minton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2817 Northwind Road, Parkville, Maryland 21234 Greq Lyston (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ¥XX Burial 2 ☐ Cremation 3 ☐ Removal from State 04/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Baltimore, Maryland Si e of Funer Service Lic 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. I Fastern Avenue, Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 88 disease condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ☐ Pregnant at time of death ☐ Unknown Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify, 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury 2 🗌 No Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29d. Date signed (Month. Dav. Year) ress or person who completed cause of death (Item 23a) (Type 21202 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle,, Last) 2. Date of Death Lineberger Month. 8:50 PM **Physician** 2017 Wilson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Loch Kaven Community Living Cente Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, June 1, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F North Carolina 239 38 3426 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 No Maryland Baltimore White Marsh Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 21162 11302 Bird River Grove Rd. HSA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or items Medical Examiner mi 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 X Yes 2 □ No If Yes, Give V Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No WW II Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Edgar Wade Lineberger Rosa Cline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ercie Patrick (Sister) 1409 Constantine St. Orlando, Florida 32825 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gardens 4/28/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 DUTKNIE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COVONAV **Physician** /Medical Due to (or as a consequence of): Examiner evelovovascul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed 1 Yes 2 ☑ 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide i 24 hours after de e Funeral Directo letely filled in by ti 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MCCRAR' MODIL LORRAINE 2:50 PM HOLLIS 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country PA 1 □ M 2 👿 F 82 Director 213-50-1503 Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD Howard Columbia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 5245 Even Star Place 21044 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gilbert Hollis Dora L. Hollen other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph McCrary/husband permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 5245 Even Star Place, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory 04/21/2010 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd, Columbia, 21. Signature Funeral Service Licensee Ü 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ LUNG CANCER disease or condition resulting in death) METASTATIC Medical Examiner Due to (or as a consequence of): PERFORATIO Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit SEPSIS Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical ANEMIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPOALBUMINEMIA 1 Yes 2 No 3 Probably 4 Unknown LEFT PLEURAL EFFUSION 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 1 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65292 APR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VILL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 Year Stanwood Moore Medical Facility Name (if not institution, give street and number) Examiner none . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country unk **Funeral** 1 ₺ M 2 🗆 F Months u 1 9 30, Year 936 73 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3318 Kerry Rd. 21207 permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked other than "notion." 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Armed Forces?unk
1 ☐ Yes 2 ☐ No Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: black Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry unk Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname)unkပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2401 W. Belvedere Avenue; Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street
Baltimore, Maryland 21201 . Enter the disease, or complications it, it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause or each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed? Yes 2 N After this certificate 2 No Yes of 4 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 Tes 2 No ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5  $\square$  Pending work 1 Tes 2 🖵 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of pers

31. Date filed (Month, Day,

completed cause of death (Item 23a) (Type, Print)

's Signature

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 23, 2010 Clara Maria Murray 6:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 13217 O**1**d Hanover Rd. Reisterstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Min Jan. 31, 1919 Maryland 215-26-7977 91 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits Director Baltimore Reisterstown MD 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 13217 Old Hanover Rd. 21136 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married ō filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: If Yes, Give "natural", Specify White XX Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Irving L. Green Katherine Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce L. Forbes/Daughter 306 Fourth St. Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial XXCremation 3 Removal from State A21 Faiths Crematory 4 Donation 5 Other (Specify) 4/26/10 Manchester, MD Chape1 Signature of June al Se e Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Tore 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Are r Sequentially list conditions, cause. Chisease or linjury Exam the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Month Day 5 Other (specify) Year the detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No Completed 1 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death?
1 Yes 2 No perfo certificate Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 2 Accident 5  $\square$  Pending 1 Yes 2 🗆 No completed filled in by the Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 🖟 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

APR 26 2010

32. Registra 's Sign

Delsters been mo 2136

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |  | For State   | State of M   | aryland /                      |                      | rtment of H  |                         | and M       | ental Hy                        | 2              | nin                           | 12827  |  |
|---|--|---|--|--------------------------------|----------------------|--|-------------------------|-------------|---------------------------------|----------------|-------------------------------|--|--|
|   |  | Registrar  1. Decedent's Name (First, Middle  | e. Last)   |                                | Cert                 | ilicate of L   | Calli                   |             | 2. Date of De                   | Reg. No.       | 010                           | 3. Time of Death                                   |  |
| Physicia  |  | Bettie Jean   | . ,  |                                |                      |  |                         |             | Month<br>04                     | 1 Day          | $20\overset{\text{Year}}{10}$ | 9:45 a M   |  |
| Medic<br>Examir   |  | 4a. Facility Name (if not institution   | n, give street and number)   |                                |                      | 4b. City, Town, or   | Location of             | of Death    | <u> </u>                        |                | unty of Death                 | 7,10   |  |
| 1   |  | 10800 Georgia   | Ave Apt #110   |                                |                      | Silver   | Spri                    | ng          |                                 | Mo             | Montgomery                    |  |  |
| Funeral<br>Director   |  | 5. Social Security Number 245-72-5882   | 6. Sex 7. Ag<br>1 ☐ M 2 🖾 F  | e (In yrs. last b<br>64        | irthday)<br>Yrs.     | If Under 1 Year<br>Months Days   | Hours Min. 8. Date of E |             |                                 | 1945           | Cour                          | place (State or Foreign<br>try)<br>ene, NC         |  |
| D wo  |  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, To                  | um as l as           | tion   |                         |             |                                 |                |                               | I0d. Inside City Limits                            |  |
| ırylanı<br>a-f sh<br>iled a   | Director   | MD Montgo   |  | Silve                          |                      |  |                         |             |                                 |                |                               | 1X Yes 2 No  |  |
| he Ma<br>or 28a<br>o notii  |  | 10e. Street and Number  |  | DIIVE                          | 1 5p1                | 10f. Zip Code  |                         |             |                                 | 10g Citizer    | n of What Cou                 |  |  |
| with t  | Funeral  | 10800 Georgia   | Ave Apt #110   | )                              |                      | 20902  |                         |             |                                 | USA            |                               |  |  |
| re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at  | Completed by Fun   | 11. Marital Status  1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ♣ Divorced   | If Yes, Give   |                                | lf.                  | Vas Decedent of Hispanic Origin? (Specify Yes or NYes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2  No Specify: |                         |             | cify Yes or No-<br>Rican, etc.) |                | ean Indian,<br>etc.           |  |  |
| -00   | ete  |   | Year or Dates.   | 16                             | Sa. Decede           | nt's Usual Occupa  | ation                   |             |                                 |                | of Business In                |  |  |
| 215   | d E  | (Specify only high<br>Elementary/Seconday (0-12)  | est grade completed)  College (1-4 or 5  | - 1                            | (Give ki<br>life, DO | nd of work done d<br>NOT use retired)  | uring most              | t of workin | g                               | 10.            |                               |  |  |
| withii<br>giene<br>'giene<br>t, the   | ပ္တို  | 12  | College (1-4 of 5  | ,+)                            | Dry (                | Cleaning   |                         |             |                                 | Clo            | thing                         |  |  |
| Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam   | 18. Mother's Name (First, Middle, Maiden Surre Warcellus Joyner Virginia Mae |   |  |                                |                      |  |                         |             | mame)                           |                |                               |  |  |
| marken matic  | -  | Marcellus Joyr  |  | i i                            |                      |  |                         | ginia       |                                 |                |                               |  |  |
| Ma<br>2 sho<br>1th and<br>1th and<br>27 is i  |  | Sheryl Mitchel  |  |                                |                      | Address (Street a  |                         |             |                                 |                |                               | pring MD 20902                                     |  |
| Te,<br>1 and<br>f Heal<br>item<br>other   |  | 20a. Method of Disposition  | - Juaugneer  | 20b, Place                     | of Disposi           | tion (Name of  | - 1                     |             | ate                             |                | ion - City or To              |  |  |
| Page nent o   |  | 1 🔀 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other 6   |  |                                |                      | atory or other place<br>it Cemete  |                         | 4/25/       | 2010                            |                | tonburg                       |  |  |
| Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other  | 1  | 21. Signature of Fuperal Service  | · · · · · · · · · · · · · · · · · · ·  | 10097                          |                      | Name and Addres  |                         |             |                                 |                |                               |  |  |
| <b>n</b> 88 = 88  |  | J. P. Ma  | rshall   |                                | 42                   | 17 9th S   | t NW                    | Was         | hingto                          | n, DC          | 20011                         |  |  |
| Pnysician/<br>Medical<br>Examiner   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Metastatic Sarcoma  Due to (or as a consequence of): |  |                                |                      |  |                         |             |                                 |                |                               | Approximate<br>Interval Between<br>Onset and Death |  |
| ed sit  | niner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)  |  |                                |                      |  |                         |             |                                 |                |                               |  |  |
| 68760<br>certificate be executed<br>nding physician and<br>use as the burial-transit  | dical Examiner   | that initiated events<br>resulting in death) Last   | a consequence  | e of):                         |                      |  |                         |             |                                 |                |                               |  |  |
| 760<br>cate b<br>physic   | edic   |   | d  |                                |                      |  |                         |             |                                 |                |                               |  |  |
| Box<br>death<br>ne atte   | by Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 21 No 9 ☐ Unknown  | 23c. If yes, outcome<br>1  Live Birth<br>4  Pregnant a<br>9  Unknown   | 2 Fetal dea                    |                      | Ectopic pregnanc<br>Other (specify)  | y                       |             |                                 | 230            | I. Date of deliv<br>Month     | ery<br>Day Year                                    |  |
| <b>Hecords, P.O.</b> The law requires that the ate has been signed by the page 2 should be detach   |  | Part II. Other significant conditi  | ons contributing to death b  | ut not resulting               | g in the un          | derlying cause giv   | en in Part I            | l.          |                                 |                |                               | ne cause of death?                                 |  |
| been<br>been<br>should  | Completed  |   |  |                                |                      |  |                         |             | 24a. Was                        |                |                               | psy findings available                             |  |
| e has   | omp  |   |  |                                |                      |  |                         |             | auto<br>perfe                   | psy<br>ormed?  | prior to co<br>death?         | mpletion of cause of                               |  |
| an: The an: The tifficat tor, pa  | Be C   | 25. Was case referred to medical  |  |                                |                      | 26. Pla  | ace of Deat             | th (Check   |                                 | 2 🗷 No         | 1 Yes                         | 2 ⊔ No   |  |
| VIT<br>nysici<br>nis ce<br>direc  | 10   | examiner?<br>1 🛣 Yes 2 □ No   | Hospital:<br>1   | ent 2 ER/0                     | Outpatient           | 3 □ DOA Othe   | r: 4 🗆 Nu               | ırsing Hon  | ne 5 🔀 Resi                     | dence 6 🗆      | Other (Specify                | )  |  |
| on of or of |  | 27. Manner of Death  1  |  |                                | . Time of injury     | 28c. Injury<br>work'<br>M 1 🗆  | at<br>?<br>Yes 2 🗆      | - 1         | 8d. Describe                    | now injury oc  | curred                        |  |  |
| DIVISION OF VITAL HECOPICS, tal or Attending Physician: The law requires rs after death.  It Director: After this certificate has been signed in by the funeral director, page 2 should be  | Certificate:   | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | not be   | ury - At home,<br>c. (Specify) | farm, stree          | t, factory, office   |                         | 2           | 8f. Location (<br>City or To    |                | ımber or Rurai                | Route Number,                                      |  |
| DIVISION Of VITAI HECC<br>To the Hospital or Attending Physician: The law<br>within 24 hours after death. To the Funeral Director. After this certificate has<br>completed filled in by the funeral director, page 2.   | Medical  | (Check 2 Medical I  | p Physician: To the best of Examiner: On the basis of each of the basis of each of the basis of the physician of the basis | xamination and                 | l/or investig        | ation, in my opinio  | n, death oc             | curred at t | he time, date                   | and place, and | d due to the ca               | use(s) and manner stated.                          |  |
| To t<br>With<br>To t  |  | 29b. Signature and title of certifie  | che  |                                |                      | 29c. License   |                         |             |                                 |                | gned (Month, 0/2010           | Day, Year)   |  |
| 3 v   |  | 30. Name and address of person 1400 Forest  |  | , ,                            |                      | ring, MD   | 2091                    | .0 Ra       | ım Treh                         | an,MD          |                               |  |  |
| Stat  |  | 31. Date filed (Month, Day, Year)   | 32. Rygistra   |                                |                      |  |                         |             |                                 |                |                               |  |  |
| Registra  | ar   | APR 2   | 6 2010 32. Registra  | un B                           | 4                    | acce   |                         |             |                                 |                |                               |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hvenue Parkui altimore 8. Date of Birth (Month, Day, Year) Feb. 17, 1928 If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 □XM 2 □ F Maryland 82 Director 217-24-8827 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Parkville MD Baltimore 1 ☐ Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 2105 Wilker Avenue 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 

 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Verizon Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Technician traumatic event, Be fled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be Thomas A.O'Keefe Lenore Wehage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Wilker Avenue-Parkville, Maryland 1234 Elizabeth O'Keefe-spouse permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter), crematory or other place)
Evans Funeral Chapel
Apr. 23,200 20c. Location - City or Town, State Burial 2 X Cremation 3 - Removal from State Forest Hill, MaRYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Service
8800 Harford Road Parkville, Maryland 21234 21. Signature of Funeral Service Licensee ondrse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final PARIZINSON Physiciani 'S DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-traneit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Dav Year Pregnant at time of death page 2 should be detached 9 Unknown P.O. signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law prior to completion of cause of death? has performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YORK ROAD LUTHERVILLE, MÁ 21093 JUBD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Physician/ Sadie Ostrow OUAN 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 X F Country) Months Days 11/9/1918 MD 91 218-10-5799 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21208 13 POMONA SOUTH, APT. filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. WHITE If Yes, Give "natural", 3 Midowed 4 ☐ Divorced Year or Dates Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATOR US GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ANNA Page 1 and 2 should be LAFFERMAN DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 STONEHENGE CIRCLE, APT. 2, BALTIMORE, MD HARRIET KAMMERMAN/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Purce of Sphall of Commerce of Commer M Burial 2 Cremation 3 Removal from State 4/23/2010 BALTIMORE, MD MEN'S CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Cardiomyopath Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, hearing to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 : performe death? 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, examiner? Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) Pattern in Spire 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A: bleted filled in by the fu Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057465 MSRijapahoeM.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

N. S. Raja Dakse, M.D. 2835 Smith Av. 5 - 203, Baltimore, MD. 21209 N. S. Rajapakse, M.D.

Registrar

State

R 2 6 20 10 Alexander

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Virginia Anne 2, Date of Death 3. Time of Death Potter Physician/ Month 4 / 17 Pay 2010 Year 3:18aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton 5. Social Security Number 232-48-2449 9. Birthplace (State or Foreign Country) WV 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Min. (Month Day, Year) 4/1/1933 1 M 25 F 77 Months Hours Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edica Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cecil Elkton 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 360 Nottingham Road Funeral 21921 USA 1 and 2 should be filed within 72 hours after death v of Health and Mental Hygiene. I flem 27 is marked other than "natural", or items if the Traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. white Specify: 3 →Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve John Paul Hyler Edna Bennett Hyler Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 360 Nottingham Road, Elkton MD 21921 19a. Informant's Name/Relationship (Type, Print) Richard Potter/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ARemoval from State Potter Family Cem 4/24/10 Todd, NC 4 ☐ Donation 5 ☐ Other (Specify) Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue Baltimore MD 21. Sign of Funeral Service Licensee Victor Inc 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician myolord disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indepth) I got Exami ondac attending physician and Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) jo Month Year Day Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Furneral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 🗓 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b, Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 17 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gentifying Nurse Pranticular: To the basis of my world go, or the opinion at the time, date and place, and the result (s) and manner as stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

In cel lan un

APR 26

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIH-HIU,MD

32. Registrar's Signature

Wer

17/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ıstin Samuel F  | -                | St<br>1- For State   | ate of Man         | /land /                | Depa               | rtment of<br>tificate of | Heal                | th and              | Menta                                       | al Hy      | giene                         | 2                | 010          | 1283                                      |  |
|---|------------------|--|--------------------|------------------------|--------------------|--------------------------|---------------------|---------------------|---|------------|-------------------------------|------------------|--------------|---|--|
| Dhysicis  |                  | Registrar  1. Decedent's Name (First, Midd   | le Last)           |                        | Cer                | uncate of                | Deal                |                     |   | 12         | Re<br>2. Date of Deat         | g. No.<br>h      |              | 3. Time of Death                          |  |
| Physicia<br>edical Exami  | - U U            | Gustin Samuel  | Page               |                        |                    |                          |                     |                     |   |            | Month<br>April 23, 2          | 010              | Year         | 1903 hrs                                  |  |
|   |                  | 4a. Facility Name (if not institution  Baltimore Washington  |                    |                        |                    | ľ                        | 4b. City, 1<br>Anna |                     | ocation of                                  | Death      |                               |                  | Arundel      |   |  |
| Funeral   |                  | 5. Social Security Number  | 6. Sex             |                        | (In yrs. la        | st birthday)             | If Und              | er 1 Year           | If Under                                    | 24Hrs.     | 8. Date of Birt               | th (MM/DD/Y      |              | thplace (State or                         |  |
| Director  |                  | 096-72-1594  | 1 M 2              | F 2                    | 5                  | Yrs                      | Month               | s Days              | Hours                                       | Min.       | 4-20-                         | 1985             | Foreig<br>Co | <sup>n</sup><br><sup>untry)</sup> Germany |  |
| _   | ļ                | Usual Residence of Decedent  |                    |                        | 10. 01             | Town or Locat            |                     |                     |   |            |                               |                  |              | 10d. Inside City Limits                   |  |
| w any   |                  | 10a. State 10b. County   | 1                  |                        |                    |                          | ion                 |                     |   |            |                               |                  |              | 1 Yes 2 XNo                               |  |
| Maryland<br>28a-f show<br>d at once.  | 호                | MD Howard  | <u>.</u>           |                        | па                 | anover                   | 10f, Zip Code       |                     |   |            |                               | Og. Citizen o    | f What Cou   |   |  |
| with the Maryland<br>ms 23a or 28a-f sho<br>be notified at once.  | į                |  | o Ct               |                        |                    |                          |                     |                     |   |            | Ι.                            |                  |              | ,   |  |
| vith th<br>s 23a<br>e notil   | a l              | 7527 Lemon Tre   |                    | Decedent E             | ver in U.          | S. 13. Wa                |                     | 1706<br>ent of Hisp | anic Origin                                 | 1? ( Spe   | cify Yes or No-               | USA<br>- 14. R   |              | can Indian, Black,                        |  |
| death w   | Funeral Director | 1 Never Married 2 X M  |                    | Forces?_               | No                 |                          |                     |                     | n, Mexican, Puerto Rican, etc.) White, etc. |            |                               |                  |              |   |  |
| ffer de ll", or   | by F.            | 3 Widowed 4 Div  | orced If Yes, Give |                        |                    | 1 Yes 2 No specify:      |                     |                     |   |            |                               | Spec             | ify: Bla     | ck  |  |
| ours a  |                  | 15. Decedent's Education (Spe  |                    |                        |                    | 16a. Deceden             |                     |                     | on (Give kir<br>OO NOT us                   |            |                               | 16b. Kind o      | f Business/I | ndustry                                   |  |
| 6 n 72 h  | Set              | Elementary/Secondary (0-12)  | College            | e (1-4 or 5-<br>1      | +)                 | _                        |                     |                     |   |            | ,                             | Security         |              |   |  |
| withingrene   | E                | Tild   Security   Se |                    |                        |                    |                          |                     |                     |   |            | First, Middle, N              |                  |              |   |  |
| e filectal Hyrith   | BeC              | Henry Page   | ,,                 |                        |                    |                          |                     |                     | Donna                                       | a Pr       | octor                         |                  |              |   |  |
| 21;<br>ould b<br>d Men<br>s mar   | ျှ               | 19a. Informant's Name/Relations  | ship (Type, Print) |                        |                    | 19b. Mailing             | Address             | (Street             | and Numb                                    | er or Ru   | ral Route Num                 | nber, City or    | Town, State  | , Zip Code)                               |  |
| b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once |                  | Helnida Page   |                    | Wife                   |                    |                          |                     |                     |   |            | over,                         |                  |              | Town, State                               |  |
| or Hea  |                  | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. 1 Burial 2 X Cremation 3 Removal from State   |                    |                        |                    |                          |                     |                     |   | 20¢, Locat | ion - City or                 | rown, State      |              |   |  |
| Page<br>ment c  | ļ                | 4 Donation 5 Other S   | pecify:            |                        |                    | Arunde                   |                     |                     |   |            | -2010                         |                  |              | aryland                                   |  |
| Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.   |                  | 21. Signature of Funeral Septice   | Licensee           |                        | 101                | 22. N<br>  Do            | lame and<br>naId    | Address of Son I    | inera<br>uner                               | al H       | lome &                        | Cremat           | ory,         | P.A.                                      |  |
| Physician   | -                | 23a Part I. Enter the disease, or  | complications that | at caused t            | MO1<br>he death.   | 1/0   14                 | II A                | napoı               | lis Ko                                      | oaa        | uaento:                       | n mary           | riand        | Approximate Interval                      |  |
| Medical   |                  | failure. List only one cause Immediate Cause (Final disease  | B. C 142 1 1       | Iniuries               |                    |                          |                     |                     |   |            |                               |                  |              | Between Onset and<br>Death                |  |
| Examiner  |                  | or condition resulting in death)   | Due to (or a       |                        | quence of          | ):                       |                     |                     |   |            |                               |                  |              |   |  |
|   | ē                | Sequentially list conditions, if any, leading to immediate   | b<br>Due to (or a  | s a consec             | quence of          | ):                       |                     |                     |   |            |                               |                  |              |   |  |
|   | Examiner         | cause. Enter Underlying Cause (Liscose or Injury that initiated  | c.<br>Due to (or a | e a canco              | augnes of          | J.                       |                     |                     |   |            |                               |                  |              |   |  |
| executed<br>an and<br>al - transit  | Ĕ                | events resulting in death) Last  | d                  | 15 a CO11560           |                    | <i></i>                  |                     |                     |   |            |                               |                  |              |   |  |
| ~ o .2.c  | dical            | UNPENDED AMENDED   |                    |                        |                    |                          |                     |                     |   | L          |                               |                  |              |   |  |
| Box 68760, e death certificate be the attending physicied for use as the buri   | Physician/Me     | IF FEMALE:<br>23b. Was decedent pregnant in t  |                    | es, outcome<br>e birth | e of pregr         |                          | tal death           | 3 [                 | Ectopic p                                   | oregnan    | cv                            | 23d. Dat<br>Mont | e of deliver | /<br>Day Year                             |  |
| x 68<br>h certi<br>tendin<br>use a  | ici a            | past 12 months?  | 4 Pr               | egnant at t            | ime of de          | -th -                    | her (Spe            |                     |   |            |                               |                  |              | ,   |  |
| m a sal   | hys              |  |                    | known                  |                    |                          | and and deep        |                     | in Dead                                     |            | 220 Did to                    | bacca usa s      | ontributo to | the cause of death?                       |  |
| ords, P.O. I w requires that the as been signed by the  | þ                | Part II. Other significant condi   | ions contributin   | g to death             | but not re         | esulting in the u        | ınderiying          | cause gn            | ven in Part                                 | . I.       | 1 Yes                         |                  |              | pably 4 Unknown                           |  |
| ds,<br>equire<br>een sig<br>ould b  | Completed        |  |                    |                        |                    | ***                      |                     |                     |   | _          | 24a. Was                      |                  |              | topsy findings available                  |  |
| tal Records ian: The law requirentificate has been  | ď                |  |                    |                        | _                  |                          |                     |                     | 111   | -          |                               | med?             | death?       | completion of cause of                    |  |
| Re<br>ifficate<br>or, pag   |                  | 25. Was case referred to medica  |                    |                        |                    |                          |                     | 26.Place o          | of Death (C                                 | heck or    | 1 Yes                         | 2 No             | 1 🗸 Y        | es 2 No                                   |  |
| Vital<br>hysiciar<br>this cert<br>1 directo   | Be               | examiner?  1 ✓ Yes 2 No  | Hospital: 1        | Inpatier               | nt 2 🗸             | ER/Outpatient            |                     |                     | Mhan —                                      |            |                               | Residence        | 6 Othe       | r.  |  |
| n of \ding Ph. h. After tl  | n: To            | 27. Manner of Death  | 28a. D             | ate of Injur           | y<br>ar)           | 28b. Time of I           | njury               | 28c. Injury         | _   | l N        | 28d. Describe I<br>Notorcycle |                  |              | vith car                                  |  |
| ion<br>frendi<br>leath.<br>for: /   | atio             | 1 Natural 5 Pen 2 ✓ Accident Inve  | stigation          |                        |                    | 1816 hrs                 |                     |                     | es 2 🗸 N                                    | No         |                               |                  |              |   |  |
| Division of Vital Records, Hospital or Attending Physician: The law requint 44 hours after death. Funeral Director: After this certificate has been s lety filled in by the funeral director, page 2 should t                                 | Certification:   | 3 Suicide 6 Cou  | ld not be 28e. F   |                        |                    | ome, farm, stre          |                     | , office bu         | ilding, etc.                                | - 1        | or Town S                     | tate)            |              | ral Route Number, City Hanover, Md.       |  |
| E 6 P   |                  | 4 Homicide  29a. Certifier   | hysician: To the   |                        |                    | d / Highway              |                     | time dat            | e and plac                                  |            |                               |                  |              |   |  |
| To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medical          | one) 2 Medical Exa   | miner: On the ba   | sis of exam            | ination a          | nd/or investiga          | tion, in m          | y opinion,          | death occu                                  | urred at   | the time, date                | and place, a     | nd due to th | e cause(s)                                |  |
| To with   | Me               | 29b. Signature and title of certifi  | and manne<br>er    | or stated.             |                    |                          | 29                  | c. License          | number                                      |            |                               | 29d. Date        | signed (Mo   | nth, Day, Year)                           |  |
|   |                  | Marie Ma Shill O.C.M.E. April 24, 2010   |                    |                        |                    |                          |                     |                     |   |            |                               |                  |              |   |  |
| 1   |                  | 30. Name and address of person   |                    |                        |                    |                          | one Ct              | root B-             | ltime c ==                                  | MDO        | 1201                          |                  |              |   |  |
|   |                  | Margarita Korell MD.   | Assistant N        | /ledical l             |                    |                          |                     |                     | Itimore,                                    | IVIU Z     | 1201                          |                  |              |   |  |
| S:<br>Regis   | tate<br>trar     | 31. Date filed (Month, Day, Year)  | 6 2010   32        | A 1                    | s Signatu<br>sulid | B. 10                    | arka                |                     |   |            |                               |                  |              |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 202010 Vathani PRIL 10:15 PM nomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL 6. Sex . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1**X**M 2□ F 213-26-903 Director 30, 1933 ary/ana Usual Residence of Deceden 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 MYes 2 □ No If Yes, Give Year or Dates: / 952 tems ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married o, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MNICIAN h and Mental Hygier Is marked other the 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surna 1 and 2 should be eanor 19a Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if Item 27 is any injury or other trau Roga 3683 Gern Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Forest 28-10 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician ARRYTHMLA MINUTES /Medical Due to (or as a consequence of) Examiner DISEASE SCHEMIC MEART EARS Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and buriat-tran Due to (or as a consequence of): the attending physician Physician/Medical the SS IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe MPHYJEMA 1 Yes 2 No 3 ☐ Probably 🔏 🖽 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Year 2 □ No 24a. Was an has page 2 autopsy certificate 2 ☐ No Yes Physiclan: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 24 No Hospital: Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of De Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier DecertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 10v 900 ATON AVE BALTIM DRE MO21229 Registrar's Signati State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 803 Physician/ Year awrence 10 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) 4(1/13)1/129/4\9ar) NY Yrs. Director 102-40-1672 61 Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director items 23a or 28a-f s ner must be notified 1 ☐ Yes 2 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Cod 10g. Citizen of What Country? Funeral 9629 Ashmede Drive United States death 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Examiner Armed Forces? 1 Never Married 2 Married ò ò Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) I. T. Industry Δ Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Department of Health and Ment Important: If item 27 is marked any injury or others Patrick Ricci Helen McCown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9629 Ashmede Drive Ellicott City, MD 21042 <u> Christine Ricci - Wife</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Cem. of the Ascension 1 Burial 2 Cremation 3 Removal from State 4/27/10 Monsey, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Si au e of Funeral Service Li. e 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute muy cardisl w disease or condition Medical Due to (or as a conseq once of): resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Live Birth 2 ☐ Fetal dea
Pregnant at time of death Day Month Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 No has certificate 25. Was case referred to medica **Division of Vital** director, Be 26. Place of Death (Check only one) examiner' Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Matural 5  $\square$  Pending work?
1 Yes 2 No after death. Director: Aft 2 Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, þ 4 Homicide determined within 24 hours after
To the Funeral Directory Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D 0026575 04/23 12010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 10155 YORK RD STELOO COCKEYSVILLE, MD J. HARTIG, M.D 21030

State

Registrar

31. Date filed (Month, Day, Year)

APR 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Ritchey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MBERLA If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7 Age (In vrs. last birthday) 6 Sex **Funeral** Sept 8, 1933 Hours Min 1 🗆 M 2 🖾 F Pennsylvania 76 289-32-7015 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Cumberland 1 Yes 2 No Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21502 901 Seton Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11 Marital Status Black White etc. þ 1 Never Married 2 Married Yes 2X No Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No white Specify. Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) elementary school teacher education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Linsley Margaret Hodil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Merkel; daughter 1st Ave; PO Box 225; Hyndman, Pennsylvania 15545 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4X Donation 5 Other (Specify) 21. Signatur Funera Id wade, State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Breast Immediate Cause (Final Physician/ Metastatic disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 10 2 200 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 00055325 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberlana 925 Bishop SHIN MD Rol 31. Date filed (Month, Day, Year) Raistrar's Signature State APR 26

DHMH 17 Rev 7/2009

Registrar

**ORIGINAL** 

| I0-02951<br>Jeffrey M. Summen  |   | Indelible Ink. Ensure All Copies partment of Health and Mental Hyd  |  |
|--|---|---|--|
|  | ·   | ertificate of Death   | Reg. No. 2010 12835  |
| Physician/<br>Medical Examiner   | Decedent's Name (First, Middle, Last)   | 110   | Date of Death Month Day Year April 15, 2010  3. Time of Death 1551 hrs           |
|  | Facility Name (if not institution, give street and number)     21610 Liberty Street   | 4b. City, Town, or Location of Death Lexington Park   | 4c. County of Death St. Mary's   |
| Funeral<br>Director  | 219-80-2782 <sub>1</sub> Km <sub>2</sub> F 48   | last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.  | B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Mary Land country) |
| ž.   | Usual Residence of Decedent  10a. State 10b. County 10c. Cit  | ty, Town or Location  | 10d. Inside City Limits  |
| Maryland<br>28a-f show any<br>dat once.<br>ector   | Maryland St. Mary's   | Lexington Park  | 1 Yes 2 No   |
| death with the Maryland or items 23a or 28a-f sho must be notified at once uneral Director   | 10e. Street and Number 21610 Liberty Street   | 10f. Zip Code<br>20653  | 10g. Citizen of What Country? USA  |
|  | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 2 Widowed 4 Divorced of If Yes, Give Year or Dates:     | U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri  1 Yes 2 No specify:                     |  |
| 11215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "natural", event, the Medical Examiner. o Be Completed by | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  1 2th grade | 16a. Decedent's Usual Occupation (Give kind of wor during most of working life. DO NOT use retired Air Craft Engineer |  |
| 5-00<br>led wit<br>Hygien<br>other<br>the Mc   | 17. Father's Name (First, Middle, Last)   | 18.Mother's Name (F   | irst, Middle, Maiden Surname)  |
|  | George Summerville  | Elva No   | orris  |
| Should be fill should be fill and Mental H. 7 is marked natic event,   | 19a. Informant's Name/Relationship (Type, Print) Cousin<br>Adrienne Suggs-Coleman   | 19b. Mailing Address (Street and Number or Rur  |  |
| ore, MD s I and 2 sho of Health and If item 27 is ret traumati   |   |   | Baltimore, Maryland 21218  |
| imore, MD 2 Pages 1 and 2 shou ment of Health and A tane: If item 27 is n or other traumatic   | 1 Burial 2 X Cremation 3 Removal from State   | crematory or other place)   | 22/10 Baltimore, Maryland  |
| Baltimore permit. Pages 1 a Department of He Important: If it injury or other I  | 21. Signature of Funeral Service Icensee  | 22. Name and Address of Facility Chat   | man-Harris Funeral Home<br>Rd Baltimore,MD 21215                                 |
| Physician<br>/Medical  | 23 Part I. Enter the disease, or complications that caused the deat<br>failure. List only one cause on each line.             |   |  |

Examiner

Division of Vital Records, P.O. Box 68760,

| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit |
|--|
|--|

|                   | or condition resulting in death)   | Due to (or as a consequence                                   |                            | scular disea                     | ise   |
|-------------------|--|---|----------------------------|----------------------------------|---|
| Examiner          | events resulting in death) Last  | Due to (or as a consequence c. Due to (or as a consequence d. |                            |                                  |   |
| dical             | X UNPENDED   | AMENDED   | rmE. g902                  | 4/29/10 TT                       |   |
| Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pre                                   | egnancy<br>2 Fetal death   | 3 Ectopic pregr                  | 23d.  |
| Completed by P    | Part II. Other significant condition   | s contributing to death but not                               | resulting in the underlyin | g cause given in Part I.         | 23e. Did tobacco us  1 Yes 2   24a. Was an autopsy performed?  1 Yes 2 No |
| Bec               | 25. Was case referred to medical   |   |                            | 26.Place of Death (Check         | only one)   |
|                   | examiner?  1 Yes 2 No  | Hospital: 1 Inpatient 2                                       | ER/Outpatient 3            | OOA Other Nursi                  | ng Home 5 Residen   |
| Certification: To | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investige                      |   | 28b. Time of Injury        | 28c. Injury at Work?  1 Yes 2 No | 28d. Describe how injury  |
| Sertific          | 3 Suicide 6 Could not determine  | ot be 28e. Place of Injury - At                               | home, farm, street, factor | y, office building, etc.         | 2Bf. Location (Street and or Town, State)                                 |
| =                 | 29a. Certifier 1 Certifying Physi  | ician: To the hest of my knowle                               | dge death occurred at the  | e time, date and place, an       | d due to the cause/s) and   |

Date of delivery **Nonth** Day Year se contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes ce 6 Other: Scene ocurred d Number or Rural Route Number, City Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 16, 2010

State Registrar

DOME

Laron Locke MD.

31. Date filed (Month, Day, Year)
APR 2 6 2010

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |   |                  | . For   | State of Ma   | aryland                           | d / Depa               | artment of H  | lealth and I                   | Mental Hy                              | giene               | Logibioi  |  |  |
|------------|---|------------------|---|---|-----------------------------------|------------------------|---|--------------------------------|--|---------------------|---|--|--|
|            | -   |                  | State Registrar   | 04)   |                                   | Cer                    | tificate of L   | Death                          |  | Reg. No             | 2010  | 12836  |  |
|            | Physicia<br>Medic   |                  | 1. Decedent's Name (First, Middle, La.  | 1. SHEW   | IBK                               | 1106                   |   |                                | 2. Date of De                          | 22                  | / /Year   | 3. Time of Death 0855 A M                          |  |
| لر         | Examin  | er               | 4a. Facility Name (if not institution, give<br>Tate Hospice   |   |                                   |                        |   | Location of Death              |  | 4c.                 | 4c. County of Death  Anne Arundel                 |  |  |
|            | Funeral<br>Director   |                  | 5. Social Security Number 6. S<br>216 20 2441   |   | (In yrs. las<br>34                | st birthday)<br>Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min. | 8. Date of Bird<br>(Month, Da<br>01/02 |                     | 9. Birthplace (State or Foreign Country) Maryland |  |  |
|            | nd<br>at  | ١                | Usual Residence of Decedent  10a, State 10b, County   |   | 10c, City.                        | Town or Lo             | cation  | -                              |  |                     |   | 10d. Inside City Limits                            |  |
|            | Marylar<br>Ba-f sl  | Funeral Director | Maryland Anne   | Arundel   |                                   |                        | cum Heigh   | ts                             |  |                     |   | 1 🗌 Yes 2 🏿 No                                     |  |
|            | th the lagarda  | a Di             | 10e. Street and Number  |   |                                   |                        | 10f. Zip Code   |                                |  | 10g. Cit            | izen of What Co                                   | untry?   |  |
|            | ath wi  | nue              | 420 Madingley 1   | Road  12. Was Decedent E                                | ver in U.S.                       | . 13. \                |   | 1090<br>ispanic Origin? (Sp    | ecify Yes or No-                       |                     | U.S.A.<br>14. Race - Amer                         | ican Indian  |  |
| 030        | e filed within 72 hours after death with the Maryland<br>Hyglene.<br>ad other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at.  | ۵                | 1 ☐ Never Married 2 🏝 Married 3 ☐ Widowed 4 ☐ Divorced  | Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates. | No                                | - 1                    | Nas Decedent of Hi<br>f Yes, specify Cuba<br>I ☐ Yes 2 🎦 No |                                | Rican, etc.)                           | - 1                 | Black, White, etc.  Specify: White                |  |  |
| 9500-c12   | 2 hour<br>"natu<br>edical   | plet             | 15. Decedent's E<br>(Specify only highest gr  |   |                                   | 16a. Deced             | dent's Usual Occup  | ation<br>during most of work   | king                                   | 16b. K              | ind of Business I                                 | industry   |  |
| 7          | within 7.<br>ygiene.<br>her than<br>t, the Me   | e Completed      | Elementary/Seconday (0-12) 12th   | College (1-4 or 5                                       | +)                                | life. D                | ONOT use retired)  ite Man                                  |                                |  |                     | Cloverla  | nd Dairy   |  |
| yland      |   | To Be            | 17. Father's Name (First, Middle, Last)   | Elmer Shev  | vbrid                             | ge Sr                  |   | 18. Mother's Nam               | Maiden Rice                            | - ·                 |   |  |  |
| Mar        | 12 shulth a   |                  | 19a. Informant's Name/Relationship (7<br>Esther Shewbrid  |   | ng Address (Street a<br>Madingley |                        |   |                                |  | MD. 21090           |   |  |  |
| gaitimore, | e = + 5   |                  | 20a. Method of Disposition<br>1 ∰ Burial 2 ☐ Cremation 3 ☐  | ☐ Removal from State                                    |                                   | metery crer            | sition (Name of<br>natory or other plac                     | ce)                            | Date                                   |                     | ocation - City or                                 | Town, State<br>.e, Maryland                        |  |
|            | nit. Page<br>partment c<br>cortant: If<br>injury or<br>ie.  |                  | 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licenter)  |   | Gle                               | n Have                 | en Mem. P  2. Name and Addres                               | ark i U4/.                     | once Fur                               |                     |   | · · · · · · · · · · · · · · · · · · ·              |  |
| ŭ          | perm<br>Depa<br>Impo<br>any i   | 8 1              | Donnam Zorg   | miroust   | w                                 |                        | 4001 Ritc   | hie High                       | way Bal                                | ltimo               | ore, Mar  | yland 21225  |  |
| Ţ          | hysician/   | u a              | 23a. Part 1. Enter the disease for com<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition | nplications that caused<br>one cause on each line.      | the death.                        | . Do not ente          | er the mode of dyin   | g, such as cardiac             | or respiratory ar                      | rest,               |   | Approximate<br>Interval Between<br>Onset and Death |  |
|            | Medical<br>Examiner   |                  | resulting in death)   | Due to (or as a   | conseque                          | ence of):              |   |                                |  |                     |   |  |  |
|            | _ ±   | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | b. Due to (or as a                                      | conseque                          | ence of):              |   |                                |  |                     |   |  |  |
|            | te be executed<br>hysician and<br>he burial-transit   | Examiner         | Cause Ulisease of injury that initiated events resulting in death) Last Due to (or as a consequence of):                          |   |                                   |                        |   |                                |  |                     |   |  |  |
| 2          | te be e.<br>nysiciar<br>ne buris  | lical            | d   |   |                                   |                        |   |                                |  |                     |   |  |  |
| 200        | ertificat<br>ding ph  | /Mec             | IF FEMALE:  | 23c. If yes, outcome of                                 | of pregnan                        | ncv                    |   |                                |  | $\neg$              |   |  |  |
| POX        | death or<br>the attended<br>hed for us  | Physician/Me     | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |   | 2 🗀 Fetal                         | death 3                | Ectopic pregnand Other (specify)                            | СУ                             |  |                     | 23d. Date of delivery  Month Day Year             |  |  |
|            | hat the<br>ed by t<br>detach  | y Ph             | Part II. Other significant conditions of  | contributing to death bu                                | ıt not resu                       | ılting in the u        | ınderiying cause giv  | ven in Part I.                 | 23e. Did t                             | obacco u            | use contribute to                                 | the cause of death?                                |  |
| as, I      | quires<br>en sigr   | ted b            | Dementia  |   |                                   | -                      |   |                                | 1 🗆                                    | Yes 2               | □ No 3 □ P  | robabiy 4 hknown                                   |  |
| Kecords,   | law rei<br>has be<br>ie 2 sho   | Completed by     | Diobetes-   | Type I  |                                   |                        |   |                                | 24a. Was<br>auto                       |                     |   | topsy findings available completion of cause of    |  |
| Ĭ          | in: The<br>ificate<br>or, pag   | e Co             | 25. Was case referred to medical  | J'  |                                   |                        | 26 PI   | ace of Death (Chec             |  | psy<br>ormed<br>2 [ | o 1 Tes   | 2 🗆 No   |  |
| VItal      | ysicía<br>lis cert<br>direct  | To B             | examiner?<br>1  Yes 2 No  | Hospital:   | nt 2 🗆 E                          | ER/Outpatier           | nt 3 DOA Oth  | er                             |  | dence 6             | ther (Spec  | ity) TATE  |  |
| n 01       | ding Pt<br>th.<br>After tf<br>funeral   |                  | 27. Manner of Death  1 Aratural 5 Pending 2 Accident Investigatio   | 28a. Date of injur<br>(Month, Day                       | y<br>Year)                        | 28b. Time of<br>injury | work  |                                | 28d. Describe I                        | how injur           | y occurred  | 1480SC   |  |
| IVISION    | or Atten<br>after deat<br>Director:<br>in by the  | Certificate:     | 2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined   | be 28e Place of Inju                                    |                                   | ne, farm, str          |   | 100 2 2 110                    | 28f. Location (<br>City or Tox         |                     |   | ral Route Number,                                  |  |
| )          | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. | Medical          | (Check 2`☐ Medical Exam   |   | amination                         | and/or inves           | tigation, in my opinio                                      | on, death occurred             | at the time, date a                    | and place           | e, and due to the                                 | cause(s) and manner stated                         |  |
|            | To the within To the Compl  | W                | only one) 3 L Certifying Nur 29b. Signature and title of certifier  | rse Practioner: To the b                                | 011                               | MAX                    | 29c. License  |                                | ice, and due to tr                     |                     | te signed (Mont)                                  |  |  |
|            | 1   |                  | 30 Name and address of person who   | completed cause of de                                   |                                   | 23a) (Type, F          | Print) ULL  | Vale 110                       | » //                                   | . 1                 | 111071  | 12 MD 215  |  |
|            | $\omega v$  |                  | QUIAN/ H-   | AKILLY  | 7.15                              | 1000                   | 173 L   | JUI UNSC                       | MUU                                    | 10                  | WILLAM  | 11/01/1  |  |

State Registrar 31. Date filed (Month, Day, Year)

APR 26 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |   | ,                | For<br>State<br>Registrar  | State of Maryland / D  | epartment of H<br>Certificate of D   |   |  | ne<br>. No. 2010                             | 12837   |  |  |  |
|--|---|------------------|--|--|--|---|--|--|---|--|--|--|
|  | Physicia  | ın/              | 1. Decedent's Name (First, Middle, Last)   | 3. Sanders   |  |   | 2. Date of Death<br>Month                      | Day Year                                     | 3. Time of Death  |  |  |  |
|  | Medic<br>Examin   |                  | 4a. Facility Name (if not institution, give str<br>Saint Joseph  | reet and number)   | 4b. City, Town, or   |   |  | 4c. County of Dea                            |   |  |  |  |
|  | Funeral   |                  | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last birth   |  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth<br>(Month, Day, Ye            | g. Bii                                       | rthplace (State or Foreign ountry)                      |  |  |  |
|  | Director<br>≥   |                  | Usual Residence of Decedent  |  |  |   | Mar.21,  | 1908l s                                      | . C   |  |  |  |
|  | ryland<br>I-f sho<br>ied at   | ctor             | 10a. State 10b. County  MD n/a   | 10c. City, Town  | or Location imore  |   |  |  | 10d, Inside City Limits  1X Yes 2 □ No                  |  |  |  |
|  | the Ma<br>or 28s<br>e notif   | Dire             | 10e. Street and Number   | Baic   | 10f. Zip Code  |   | 10g  | . Citizen of What C                          |   |  |  |  |
|  | h with<br>ns 23a<br>nust b  | Funeral Director | 8810 Richmond  |  | 2123   | 34  |  | USA  |   |  |  |  |
| 980  | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | by               | 11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  | 2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.                                      | 13. Was Decedent of His<br>If Yes, specify Cubar                                 | spanic Origin? (Sp<br>, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)               | 14. Race - Ame<br>Black, Whit<br>Specify: B1 | e, etc.   |  |  |  |
| Baltimore, Maryland 21215-0036   | thin 72 hou<br>ene.<br>• than "natu<br>he Medical   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Seconday (0-12)   | completed) College (1-4 or 5+)   | Decedent's Usual Occupa<br>Give kind of work done du<br>ife. DO NOT use retired) | tion<br>uring most of work                          | sing 16  | b. Kind of Business                          | Industry  |  |  |  |
| nd 2   | filed wall Hygin al Hygin al other went, I  | Be               | 17. Father's Name (First, Middle, Last)  |  | ousewife   |   | ne (First, Middle, Maid                        | home<br>den Surname)                         |   |  |  |  |
| ryla   | uld be<br>d Ment<br>marker<br>natic e   | 입                | Jack Baker   | Orien)   |  | Salli   |  |  |   |  |  |  |
| Ma   | d 2 sho<br>alth an<br>n 27 is i<br>er traun   |                  | 19a. Informant's Name/Relationship (Type<br>Ruth S. White (  |  | Mailing Address (Street at 810 Richmo  |   |  |  |   |  |  |  |
| imore,   | Page 1 an ment of He tant: If iten iury or other  |                  | 20a. Method of Disposition  ↑ Burial 2 ☐ Cremation 3 ☐ Ri  4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State cemetery   | Disposition (Name of crematory or other place Ford Cem                           | )   |  | Villiams                                     | hura Co   |  |  |  |
| Ball   | permit<br>Depart<br>Impor<br>any in   |                  | 21 mature of Funeral Service Licensee  | frugg  | 22. Name and Address<br>Calvin B.  | Sof Facility<br>Scrug<br>Preston                    | gs Funer<br>St. Bal                            | al Home                                      | 21213   |  |  |  |
| _  | Physician/  |                  | 23a. Part 1. Enter the disease, or complic<br>shock, or heart failure. List only one<br>Immediate Cause (Final<br>disease or condition | ations that caused he seath. Do no cause on each line.  URINARY TRAC   |  |   | or respiratory arrest,                         |  | Approximate<br>Interval Between<br>Onset and Death      |  |  |  |
|  | Medical Examiner  |                  | resulting in death)  | Due to (or as a consequence of   | ):   |   |  |  |   |  |  |  |
|  |   | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | Due to (or as a consequence of   | ):   |   |  |  |   |  |  |  |
|  | ecute<br>and<br>I-transi  | Examiner         | Cause (Disease or influry that initiated events resulting in death) Last Due to (or as a consequence of):                              |  |  |   |  |  |   |  |  |  |
| 0  | icate be executed<br>physician and<br>sthe burial-transit   | edical           | d.   |  |  |   |  |  |   |  |  |  |
| 30x 6876   | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. | Physician/Mec    | in the past 12 m inths?  | c. If yes, outcome of pregnancy  1   | 3  Ectopic pregnancy 5 Other (specify)   |   |  | 23d. Date of delivery  Month Day Year        |   |  |  |  |
| 0  | at the od by the detache  |                  | 9 Unknown Part II. Other significant conditions cont   |  | the underlying cause give  | en in Part I.                                       | 23e. Did tobac                                 | co use contribute to                         | the cause of death?                                     |  |  |  |
| JS, F  | puires the  | ed by            | DEMENTIA   |  |  |   | 1 ☐ Yes  | 1/   | robably 4 🗆 Unknown                                     |  |  |  |
| Recor  | <b>sician:</b> The law rec<br>certificate has bee<br>lirector, page 2 sho   | Completed        |  |  |  |   | 24a. Was an<br>autopsy<br>performed<br>1 Yes 2 | prior to death?                              | ntopsy findings available completion of cause of s 2 No |  |  |  |
| ita  | sician:<br>certifii<br>irector,   | 00               | 25. Was case referred to medical examiner?  1  Yes 2  No   | spital:  | Other  | ce of Death (Chec                                   |  |  |   |  |  |  |
| <b>J</b> o   | ng Phy<br>ter this<br>neral d   | te: To           | 27. Manner of Death  | 1 Inpatient 2 ER/Outp 28a. Date of injury (Month, Day, Year) 28b. Tir  |  | at  | ome 5 Residence<br>28d. Describe how in        |  | ify)  |  |  |  |
| ion  | ttendir<br>death.<br>tor: Af<br>the fu  | Certificate:     | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be  |  | M 1□Y  | ′es 2 □ No  |  |  |   |  |  |  |
| Division of the contract of th | ital or A<br>irs after<br>al Direc<br>led in by   |                  | 4 Homicide determined  | 28e. Place of Injury - At home, farn building, etc. (Specify)  |  |   | 28f. Location (Street<br>City or Town, St      | tate)  |   |  |  |  |
|  | Hospi<br>24 hou<br>Funer<br>leted fill  | Medical          | (Check 2 \( \subseteq \text{Medical Examine} \)  | ian: To the best of my knowledge, de<br>r: On the basis of examination and/or i<br>Practioner: To the best of my knowled | investigation, in my opinion   | i, death occurred a                                 | t the time, date and pl                        | ace, and due to the                          | cause(s) and manner stated.                             |  |  |  |
|  | To the comp   | 2                | 29b. Signature and title of certifier  | 200  | 29c. License   | number  | 29d.   | Date signed (Mont                            | h, 🎝ay, Year)   |  |  |  |
|  | )   |                  |  |  | DOM  | 41410   |  | PRN 93                                       | , 2010.   |  |  |  |
|  |   |                  | 30. Name and dddreds of person who com JOGINDER F. MEI   |  | pe, Print) OSLER DR  | IVE TOU   | ISON. MAI                                      | RYLAND 8                                     | 21204   |  |  |  |
|  | Stat<br>Registra  |                  | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signature   | , .  |   |  |  |   |  |  |  |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 11FM 30 PER DVR C902 4-26-10 Vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Paul Shoemaker 8:15 9-P11 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard country Howar Colom bi d count 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Aug 19, Year 939 Months Days Hours Pennsylvania Director 70 175-28-2410 Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🖾 No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6334 Cedar Ln #202B 21044 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or . Black, White, etc þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural", Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry UNK 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) 1andscaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Aberts John Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Shoemaker/son 22098 Main Street; Hillsboro, Maryland 21641 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility Board; 655 W. Baltimore Street Raltimore Maryland 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed this certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 No ၉ 1 MInpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ϊ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D6437 15wort 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sana 2748 Millers Way Dr. Ellicott City, Md. Sa 14 31. Date filed (Month, Day; Year) 32.

DHMH 17 Rev 7/2009

Registrar

APR 26 2010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ()4 George Harry Scithers 11:50aM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min. 1 X M 2 - F 457-40-3384 80 Yrs. Director unknown Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville 1 ☐ Yes 2X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 USA 218 Blandford St. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Editor/Publisher Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Scithers Ruth McKelway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Clark / Cousin 7205 Oakridge Ave. Chevy Chase, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Ardent Crematory 4/22/2010 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Buneral Service License 22. Name and Address of Facility ) de 7522 Connelley Dr. # N. Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Ventricular Dysrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy death? certificate 2 👿 No Yes Division of Vital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 10 1 Yes 2 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hours within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nursa Fractioner: To the best of my k 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04/20/2010 166304

State Registrar

カニカ

Bethesda

MD

20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tagore

Sujov

31. Date filed (Month, Day, Year) APR 26 8600 Old Georgetown Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ye ar **Physician** SEMONES -13 ELIZABETH 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 F Director 67 06/30/1942 Pennsylvania 218-38-8982 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modest Explained at Director 1 XYes 2 No Anne Arundel Crownsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with in and Mental Hygiene.

is marked other than "natural", or items 23a or 388 Holly Trail 21032 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? 1 ☐Yes 2 ☑ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Specify ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cleaner Residential 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Charles Breen Marie McCloskev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traunonce. 388 Holly Trail, Crownsville, MD 21032 Laura Howes / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 04/22/2010 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licens e 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -du M disease or condition resulting in death) /Medical Die to (or as a consequence of) NEUMONIA Examiner Sequentially list conditions. r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □No 2/2/No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 2- No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident

law requires that the death certificate be executed and Box 68760. P.0. Division of Vital Records, death.

Baltimore, Maryland 21215-0036

attending physician for use as the buria signed by the a icate has been siç , page 2 should b certificate has Hospital or Attending Physician: funeral director, After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29b. Signature and title of certifier as

6 ☐ Could not be

APR 26

determined

3 Suicide

29a. Certifier

4 Homicide

(Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print) Name and address of pers 174 m 441 Year) Date filed (Month, Day,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |               | Please   | type or Print in  |                     |                                       |                              | •                     | •  | e.   |
|--|---------------|--|---|---------------------|---------------------------------------|------------------------------|-----------------------|--|--|
|  |               | for State  | State of Marylar  | •                   |                                       |                              | /lental Hygi          | ene                                      | 1001   |
|  |               | Registrar  | n#1   | Cei                 | tificate of L                         | Death                        |                       | g. No                                    | 0 284  |
| Physicia<br>Medic  |               | 1. Decedent's Name (First, Middle, Las<br>MORRIS   | SILBER  | PMA                 | N                                     |                              | 2. Date of Death      | 22 2                                     | 3. Time of Death                                   |
| Examin   | er            | 4a. Facility Name (if not institution, give  |   |                     |                                       | r Location of Death          |                       | 4c. County of D                          |  |
| Funeral  |               | 3601 ANTON FARMS 5. Social Security Number 6. S  |   | last birthday)      | BALTIMO<br>If Under 1 Year            | JKL<br>If Under 24 Hrs.      | 8. Date of Birth      | BALTIM                                   | UKL Birthplace (State or Foreign                   |
| Director   |               | 213-16-3420 1<br>Usual Residence of Decedent   | 7. Age (In yrs. )   | 92 Yrs.             | Months Days                           | Hours Min.                   | 12/23/                | f917                                     | Country) MD  |
| land<br>show   | tor           | 10a. State 10b. County   | 10c. Ci   | ty, Town or Lo      | cation                                |                              |                       |  | 10d. Inside City Limits                            |
| Mary<br>28a-1<br>otifie  | Director      | MD BALTIM  | ORE BA  | ALTIMOF             | RE                                    |                              |                       |  | 1 🗌 Yes 2 💢 No                                     |
| th the<br>3aor<br>t be r   | ralD          | 10e. Street and Number   |   |                     | 10f. Zip Code                         |                              | 10                    | g. Citizen of What                       | •  |
| ath wi   | Funeral       | 3601 ANTON FARM  | 12. Was Decedent Ever in U.                                     | S 13 1              | 21208                                 | lispanic Origin? (Spe        | ocify Van or No-      | 144 Poor A                               | USA  |
| or ite   | by F          | 1 Never Married 2 Married  | Armed Forces?<br>1 X Yes 2 ☐ No                                 |                     | f Yes, specify Cuba                   | an, Mexican, Puerto          | Rican, etc.)          | Black, W                                 | merican Indian,<br>hite, etc.                      |
| urs aff<br>ural",<br>Il Exa  |               | 3 M Widowed 4 Divorced   | If Yes, Give<br>Year or Dates.                                  |                     | 1 □ Yes 2 🛣 No                        | Specify:                     |                       | Specify: W                               | HITE   |
| 72 hou   | Completed     | 15. Decedent's E<br>(Specify only highest gro  |   | (Give               |                                       | during most of work          | ing 1                 | 6b. Kind of Busine                       | ss Industry  |
| ithin iene.  | Con           | Elementary/Seconday (0-12)   | College (1-4 or 5+)<br>5+                                       |                     | O NOT use retired)                    | TE DEVELO                    | PFR                   | REAL E                                   | STATE  |
| filed wall Hyg   | Be            | 17. Father's Name (First, Middle, Last)  | · ·   |                     |                                       |                              | e (First, Middle, Ma  |  | JIMIL  |
| d be dents<br>Ments<br>arked<br>atic e   | 오             | PHILIP   |   | SILBER              | MAN                                   | JENNIE                       |                       | GIN                                      | NSBERG   |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   |               | 19a. Informant's Name/Relationship (7) SUSAN SUGARMAN /  |   |                     |                                       | and Number or Rura ONY COURT |                       | -  |  |
| 1 and of Hear  |               | 20a. Method of Disposition   | 20b. I  | Place of Dispo      | sition (Name of natory or other place |                              |                       | 0c. Location - City                      |  |
| Page<br>ment<br>ant: I   |               | 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia  | fy)  Removal from State  BET                                    |                     |                                       | PARK 04/2                    | 3/2010                | RANDALL                                  | STOWN, MD  |
| permit.<br>Depart<br>Import<br>any inj<br>once.  |               | 21. Signature of Funeral Service Licens  |   | 22                  | 2. Name and Addre                     | ss of Facility SOL           | LEVINSO               | N & BROS.                                | , INC.   |
| TD = # 0   |               | 222 Part 1 Enter the disease or som  | plications that coulond the dec                                 |                     |                                       |                              |                       |  | MD 21208   |
|  |               | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only o<br>Immediate Cause (Final | ne cause on each line.  | J d                 |                                       |                              | or respiratory arrest | ,  | Approximate<br>Interval Between<br>Onset and Death |
| Physician/<br>Medical  |               | disease or condition resulting in death)   | a. Due to (or as a conseq                                       | race of:            | Ca                                    | ncon                         |                       |  | 011001 0110 00011                                  |
| Examiner   |               |  | Due to for as a conseq  | derice oi).         |                                       |                              |                       |  |  |
|  | iner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                       | b. Due to (or as a conseq                                       | uence of):          |                                       |                              |                       |  |  |
| cuted<br>ind<br>transi   | xam           | Cause (Disease or iinjury that initiated events  | c   |                     |                                       |                              |                       |  |  |
| be executed<br>sician and<br>burial-transi   | cal Examiner  | resulting in death) Last   | Due to (or as a conseq  | uence ot):          |                                       |                              |                       |  |  |
| cate to physical care to the last the l |               |  | d   |                     |                                       |                              |                       |  |  |
| rath certificate be executed attending physician and for use as the burial-transit   | Physician/Med | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of pregna                                  | ancy                | 16                                    |                              |                       | 23d. Date of                             | delivery   |
| death<br>ne atte<br>ad for   | sicia         | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1 Live Birth 2 Fet. 4 Pregnant at time of                       |                     | Ectopic pregnand Other (specify)      | cy                           |                       | Month                                    | Day Year   |
| of the   | Phy           | g ☐ Unknown  Part II. Other significant conditions c   |   | oulting in the u    | underking eques gi                    | uen in Deet I                |                       |  |  |
| The law requires that the de sate has been signed by the page 2 should be detached   | d by          | pneumo   |   | salang in the c     | indenying cause gr                    | veiriii Faiti.               | 1 \(\sum \) Yes       | _  | to the cause of death?  Probably 4  Unknown        |
| requii<br>been<br>should   | Completed     | P  |   |                     |                                       |                              | 24a. Was an           | •••                                      | autopsy findings available                         |
| ne law<br>e has<br>age 2   | omo           |  |   | <u>.</u>            |                                       |                              | autopsy<br>perform    | ed? prior death                          | to completion of cause of ?                        |
| an: Th<br>tificat<br>tor, po   | Be C          | 25. Was case referred to medical   |   |                     | 26. Pl                                | lace of Death (Checi         |                       | ¥No 1 □                                  | Yes 2 No   |
| nysici<br>nis cer<br>direc   | To B          | examiner?<br>1  Yes  No  | Hospital:<br>1  Inpatient 2                                     | ER/Outpatier        | Oth                                   | er:                          | me 5 Residen          | ce 6 Other (Sp                           | pecify)  |
| ing Pl   |               | 27. Manner of Death 1   Natural 5 □ Pending  | 28a. Date of injury<br>(Month Day, Year)                        | 28b. Time of injury | 28c. Injur<br>worl                    |                              | 28d. Describe how     | injury occurred                          |  |
| ttend<br>death<br>stor: A<br>the f   | Certificate:  | 2 Accident Investigation 3 Suicide 6 Could not b   |   |                     |                                       | Yes 2 No                     | 0011 11 101           |  |  |
| al or A<br>s after<br>I Direction by   |               | 4 ☐ Homicide determined  | building, etc. (Specify   |                     | eet, factory, office                  |                              | City or Town,         |  | Rural Route Number,                                |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 brous after death. with a Honors after death. completed filled in by the funeral director, page 2 should be detached for use as the  | Medical       | (Check 2 L Medical Exam  | sician: To the best of my know iner: On the basis of examinatio | n and/or invest     | tigation, in my opinio                | on, death occurred at        | the time, date and    | place, and due to the                    | ne cause(s) and manner stated                      |
| To the within to the To the comple   | Σ             | only one) 3 ☐ Certifying Nurs<br>29b. Signature and title of certifier                                   | se Practioner: To the best of m                                 | y knowledge, o      | death occurred at the 29c. License    |                              |                       | ause(s) and manner<br>d. Date signed (Mo |  |
|  |               | · Moass  | Soll  |                     | DI                                    | SF70                         | Z X                   | pord.                                    | 2, 2010  |
| 10 v   |               | 30. Name and address of person who   | completed cause of death (Iten                                  | n 23a) (Type, F     | Print)                                | obin de                      | Blund St              | is to A                                  | 121061   |
| Stat   |               | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signa   | ature               |                                       |                              | / 0                   | . //                                     |  |
| Registra   | -             | APR 26.2   | 010   | 1. 14               | arkel                                 | . <u></u>                    |                       |  |  |

DHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Schwartz 20 O Dolores 6:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Hours 1672671931 099-24-9327 78 **Director** NY Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Director 1 🗆 Yes 2 ื No BALTIMORE MD BALTIMURE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 8513 SNOWREATH ROAD 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo WHITE If Yes, Give Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname)
DESECCIO Be 17. Father's Name (First, Middle, Last) ဂ္ **JOHN BROWN ELIZABETH** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HILLARY GREENBERG/DAUGHTER 325 KENDIG DRIVE, OWINGS MILLS, MD 21117 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BETH EL MEMORIAL PK 4 Donation 5 Other (Specify) 4/23/2010 RANDALLSTOWN, MD 21. Ignature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death End-Stage COPD Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Tuneral DirectAre this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buna completed filled in by the funeral director, page 2 should be detached for use as the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 🎖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MS Rajapakse MD 4/22/10 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209 N.S. Rajapakse MD 5-203 2835 Smith AV 32. Regionar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

APR 26

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Louis Starvis 2010 Apri] 4:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 7903 Citadel Drive Severn If Under 24 Hrs. Hours Min. 8. Date of Birth . Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 01-04-1940 Pennsylvania Director 70 207-32-4199 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other thaumatic event, the Medical Examiner must be notified at any injury or other thaumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2X No Anne Arundel MD Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7903 Citadel Drive 21144 United States 12. Was Decedent Ever in U.S Armed Forces? 1 ፟ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 🛣 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Iron Worker Rodmans Local #201 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Starvis Sara Covitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7903 Citadel Drive Severn, Maryland 21144 Brenda I. Starvis / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 Degation 5 Other (Specify) Odenton, Maryland W. Arundel Crematory 04-24-2010 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Donaldson Funeral Home & Crematory, P.A.

Donaldson Funeral Home & Crematory, P.A. rg C Funeral Service Licenses Signati Part 1 Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine It any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit and resulting in death) Last the attending physician Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physicis Records, P.O. Box 68760 the IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death detached for in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown ant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1 🗌 Yes 2 No ျ 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 28a. Date of injury V (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation M the within 24 hours after des To the Funeral Directon completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Menth. Day, Year) istrar's Signature State 26 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20a-5, 22, per Fh 9902 4/27/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month April 19<sup>Day</sup> **Physician** 2010 11:00 ΑМ Vernon Thiess /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 305 E. Joppa Rd; #1506 Towson 8. Date of Birth (Month, Day, Sept 5, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours Min Maryland 18 M 2 □ F 1926 **Director** 83 216-20-9535 Usual Residence of Decedent the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hyglene. Important: I flem 21 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ins. Vedical Earn her count. MD Director Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ルンしいのかしいにあるのがにの 305 E. Joppa Rd; #1506 21286 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No If Yes, Give Year or Dates Specify Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) police officer law enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Henry Thiess ပ Rose Sachs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Hayman/friend 15 Elphin Ct; #302; Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4/26/2010 Metro Crematory Baltimore, MD 4 □ Donation 5 ☑ Othe win state Ronald Laryen Maryland 21201 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final · Arterioscleratic Cardio vasalor Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (of as a consequence of) law requires that the death certificate be executed and burial-tran Due to (or as a consequence of). Box 68760. physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. the 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate | perform Division of Vital 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To funeral 27. Manner of Death To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 🗆 Yes 2 🗌 No 3 ☐ Suicide 6 Could not be To the ...
Within 24 hours after ...
To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title 9 certifier 29c. License number me and address of person who completed caus of death Item 23a) (Type, Print) MD HillGT Luthonville, Md 21093  $\mathcal{C}$ 6 Trimble 0 Pay, Year) 31. Date filed (Month, State Registrar Back

DHMH 17 Rev 1/2001

11:00

0102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 16 2010 ear **TOBY** 9:40 P M LORRAINE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6 Sex Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K Country) *\$\partial* 47 13 30 MD 215-24-9877 80 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits must be notified at Funeral Director 1 Yes 2 No BALTIMORE BALTIMORE 0 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? 23a 2201 FALLS GABLE LANE, #N 21209 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. 3 XWidowed 4 Divorced Year or Dates er than "natura , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ HARRY SACHS IDA LEVY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINDY TOBY/DAUGHTER 2201 FALLS GABLE LANE, #N, BALTIMORE, MD 21209 Department of Health Important: If item 2; any injury or other tonce. 20a. Method of Disposition 20b. Placerof Disposition (Name of cemeter); crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State VETERANS CEMETERY 4/23/2010 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility INC. SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) 2120 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No ☐ Pregnant at time of death ☐ Unknown cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗸 🖰 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 2 No 1 Yes To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, a 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 0 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 103010 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier muter DA7683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller 35 South the Snike 203 Balhner 21209 3 Chate filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# operFH, G909, I1/29/2010, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 0537 Tawney Sadee Grace 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner of Balti more Baltimor If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Month Day, NONE MD Director Usual Residence of Decedent 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho Director MD 1 ☐ Yes 2 No Carroll Hampstead 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21074 USA 3726 Shiloh Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 24 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) never worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su Kristy Marie Raska Damien Christopher Tawney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is 3726 Shiloh Rd.. Hampstead, MD 21074 Kristy M. Tawney (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 20c. Location - City or Town, State Sykesville, MD 20a. Method of Disposition 4-25-10 permit. Page 1 a Department of H Important: If ite any injury or otl 1 🗆 Burial 2 Kremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Rome & Chapel Signature of Funeral Service Licenses Paigustaght Serbert

P.O. Box 195 Sykesville, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 24 Medical Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Funeral Director: After this certificate has been signed by the attending physician and ripleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျင Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 42821 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital MElinda MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

awne

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Kenneth Vorke  |              | r State  | State of                   | of Marylan                        |   | rtment of<br><i>tificate of</i>    |                                       | nd Menta                        | al Hygiene<br>R                                   | eg. No.                | 201                          | 0             | 12847  |
|--|--------------|--|----------------------------|-----------------------------------|---|------------------------------------|---------------------------------------|---------------------------------|---|------------------------|------------------------------|---------------|--|
| Physician/   | 4            | ecedent's Name (First, N                               | Middle,Last)               |                                   |   |                                    |                                       |                                 | Date of Dea     Month                             | ith<br>Day             | Year                         | 3.            | Time of Death<br>1045 hrs                      |
| Medical Examine  |              | Kenneth Facility Name (if not inst                     | itution obso               |                                   | icholas                                     |                                    | NO:                                   | rke                             | April 22, 2                                       |                        | County of D                  | eath          | 1045 1115                                      |
|  |              | Good Samaritan F                                       |                            | street and numb                   | , e.,                                       |                                    | Baltimore                             | T LOCATION OF                   | <b>.</b>  |                        | , , , , , , ,                |               |  |
| Funeral  |              | ocial Security Number                                  | 6. <b>S</b> ex             | 7.                                | Age (In yrs. la                             |                                    | If Under 1 Ye                         | _                               | Min   |                        | F                            | oreign        |  |
| Director   |              | 2-88-0737  | 1                          | M 2_F                             |   | 51 Yrs.                            | MOTRIS                                | lys Hours                       | Aug. 2  | 6 19                   | 958                          | Count         | <sub>ry)</sub> Maryland                        |
| ruy  |              | Residence of Decede<br>State 10b. Co.                  |                            |                                   | 10c. City,                                  | Town or Locati                     | on                                    |                                 |   |                        |                              | 10            | 0d. Inside City Limits                         |
| Maryland<br>28a-f show any<br>d at once.<br>rector   | ма           | ryland   | NA                         |                                   | Ba]   | Ltimore                            |                                       |                                 |   |                        |                              | 1             | X Yes 2 No                                     |
| Maryla<br>28a-f s<br>1 at ou   | 10e.         | Street and Number                                      |                            |                                   | <u> </u>                                    |                                    | 10f. Zip Code                         |                                 | 1   | l 0g. Citiz            | zen of What                  | Country       | ?  |
| th the N<br>23a or<br>10tifie  | 39           | 09 Fleetwoo  | od Av                      | enue                              |   |                                    | 2120                                  |                                 | 0 ( 0 N N N                                       |                        | U.S                          |               | Indian, Black,                                 |
| r death with the Maryland<br>or items 23a or 28a-f sh<br>must be notified at onc<br>Furneral Director  | 11. N        | Marital Status Never Married 2                         | Married                    | 12. Was Deced                     |   |                                    |                                       |                                 | n? ( Specify Yes or No<br>Puerto Rican, etc.)     | -                      | White, e                     |               | i indian, biack,                               |
| s after de real", or niner mu  | 3            | Widowed 4  | Divorced                   | 1 Yes If Yes, Give Year or Dates: | 2 14 NO                                     | 1                                  | Yes 2X N                              | o specify:                      |   |                        | Specify: W                   | hi.t          | e  |
| hours a<br>matura<br>Exami   |              | Decedent's Education                                   |                            | y highest grade                   |   |                                    | t's Usual Occup<br>ost of working lif |                                 | nd of work done<br>se retired)                    | 16b. K                 | (ind of Busin                | ess/Indu      | ustry  |
| 5-0036 ed within 72 hour hygiene. other than "natt the Medical Exal  | EI EI        | ementary/Secondary (0                                  | 1-12)                      | College (1-4<br>NA                | or 5+)                                      | Barten                             | der                                   |                                 |   | Kn:                    | ights                        | of (          | Columbus                                       |
| 5-00<br>ed with<br>tygiens<br>other  | 17. F        | ather's Name (First, Mi                                | iddle, Last)               |                                   |   | 571                                |                                       |                                 | Name (First, Middle,                              | Maiden                 |                              | o i o         | rski.  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica  | i l          | John   | tionalia (T.               | Deint )                           |   | Vork                               | January Color                         | Mar                             | er or Rural Route Nu                              | mbor Ci                |                              |               |  |
| Baltimore, MD 21215-0036  permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director   | Jo           | Informant's Name/Rela<br>hn <sup>V</sup> orke          |                            | Brothe                            | r )   | 4501                               | Summer                                | Brook                           | Way Milic   | rd,                    | Delaw                        | are           | 19963  |
| e, N. 1 and 1 Health litem   |              | Method of Disposition  Burial 2 Crem                   |                            |                                   |   | Place of Dispos<br>rematory or oth | ition (Name of c                      | emetery,                        | April   | 20c. l                 | ocation - Cit                | ty or To      | wn, State                                      |
| MOI<br>Pages<br>Sent of<br>ant: If   | 4            | Donation 5 Othe  | er Specify:                |                                   | i State                                     | red Hea                            | rt of M                               |                                 | 26,2010   |                        |                              |               | ryland   |
| Baltimore,<br>permit. Pages 1 ar<br>Department of Hee<br>Important: If ite   | 21. \$       | Signature of Funeral Se                                | rvice Licens               | ee                                | 4/  | 22 W                               | lame and Addre<br>Dahro               | ss of Facility<br>WS k1/C       | hojnacki l  | une                    | ral Ho                       | mes           | P.A.   |
| Physician  | 23a.         | Party. Enter the diseas                                | se, or compl               | ications that cau                 | sed the death.                              | Do not enter the                   | 005 Dun<br>ne mode of dying           | <u>dalk A</u><br>g, such as car | ve. Baltin<br>rdiac or respiratory ar             | rest, sho              | ock, or heart                |               | Approximate Interval                           |
| /Medical   | Imm          | failure. List only one c<br>ediate Cause (Final dis    |                            | therosclero                       | tic Cardiova                                | ascular Dis                        | ease                                  |                                 |   |                        |                              |               | Between Onset and<br>Death                     |
| Examiner   |              | ondition resulting in dea                              |                            | Oue to (or as a co                | onsequence of                               | ):                                 |                                       |                                 |   |                        |                              |               |  |
| ā  | Seq<br>if ar | uentially list conditions,<br>ly, leading to immediate | . [                        | Oue to (or as a co                | onsequence of                               | r):                                |                                       |                                 |   |                        |                              | $\dashv$      |  |
| ted<br>1<br>ansit<br>Fxaminer  | cau:<br>(Dis | se. Enter Underlying Ca<br>ease or injury that initia  | ted <sup>C.</sup> -        | Due to (or as a co                | onsequence of                               | n:                                 |                                       |                                 |   |                        |                              | $\dashv$      |  |
| uted nd ransit   | eve          | nts resulting in death) L                              | _asi d                     |                                   |   |                                    |                                       |                                 |   |                        |                              |               |  |
| te be executed ysician and burial - transit  |              | UNPENDED   |                            | AMENDED                           |   |                                    |                                       |                                 |   |                        |                              |               |  |
| 376C<br>ificate<br>ig phys<br>s the b  |              | EMALE:<br>Was decedent pregnan                         | t in the                   | 23c. If yes, ou                   | tcome of pregr                              |                                    | tal death 3                           | Ectopic                         | pregnancy   | 230                    | d. Date of de<br>Month       | livery<br>Day | Year   |
| Box 6876  e death certificate the attending phy ed for use as the by   | 5<br>6 1     | past 12 months?  | Unknown                    | I'H                               | Pregnant at time of death 5 Other (Specify) |                                    |                                       |                                 |   |                        |                              |               |  |
| Vital Records, P.O. Box 68760, ysician: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transition Re Completed by Physician/Medical E-   | Part         | II. Other significant co                               |                            | 9 Unknow                          |   | esulting in the u                  | inderlying cause                      | e given in Par                  | t I. 23e. Did t                                   | tobacco                | use contribu                 | te to the     | cause of death?                                |
| P.C es that igned I be deta  |              |  |                            |                                   |   |                                    |                                       |                                 | 1Ye   | s 2                    | No 3                         | Probab        | ily 4 🗸 Unknown                                |
| rds, requir  |              |  |                            |                                   |   |                                    |                                       |                                 | 24a. Was<br>auto                                  | psy                    | prio                         | r to com      | osy findings available<br>apletion of cause of |
| Records, The law requires ficate has been signage 2 should be  | 5            |  |                            |                                   |   |                                    |                                       |                                 | perfo<br>1 <b>✓</b> Yes                           | ormed?<br>2 N          | o dea                        | th?<br>Yes    | 2 No   |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the and red death.  The rector: After this certificate has been signed by led in by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach by Dartification: To Be Commissed by Dartification:   |              | Was case referred to me                                | _                          | ospital:                          |   |                                    |                                       | Othor:                          | Check only one)                                   | 1                      |                              | 211           |  |
| of Viting Physical directal di | 27           | 1 ✓ Yes 2 No<br>Manner of Death                        | <u> </u>                   | 28a. Date of                      | -   | ER/Outpatient<br>28b. Time of I    | -                                     | jury at Work?                   | Nursing Home 5 28d. Describe                      | Reside                 |                              | Other:        |  |
| on of onding Phath.  The function of the funct | 1 9          | ✓ Natural 5  | Pending                    | (Month, D                         | oay,Year)                                   |                                    | 1_                                    | Yes 2                           | No  |                        |                              |               |  |
| Division o spital or Attending hours after death eneral Director: After filled in by the fune Contification:   | 3 3          | Accident Suicide 6                                     | Investigation Could not be | 28e. Place                        | of Injury - At ho                           | ome, farm, stre                    | et, factory, office                   | building, etc                   | . 28f. Location or Town,                          |                        | nd Number                    | or Rural      | Route Number, City                             |
| Di<br>Spital spital hours a hours a filled   | 4 [          | Homicide   | determined                 | (44)                              |   |                                    |                                       |                                 |   |                        |                              |               |  |
| Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  | (Che         | Certifier 1 Certifyi                                   | ng Physici:<br>I Examiner: | On the basis of                   | examination a                               | ge, death occui<br>nd/or investiga | red at the time,<br>tion, in my opini | date and plac<br>on, death occ  | ce, and due to the cau<br>urred at the time, date | ise(s) ar<br>e and pla | id manner as<br>ace, and due | to the c      | cause(s)                                       |
| To with To com   | 29b          | Signature and title of c                               | ertifier                   | and manner sta                    | ted   |                                    | 29c. Lice                             | nse number                      |   | 29d.                   | Date signed                  | (Month        | , Day, Year)                                   |
|  |              | The l  | M.                         | Kina                              | TRI. M                                      | u. A.                              | 0.0                                   | C.M.E.                          | OGME  | Apr                    | il 23, 201                   | 0             |  |
|  |              | Name and address of p                                  |                            |                                   | of death (Item                              | ,                                  | 111 Donn S                            | Street Ball                     | timore MD 2120                                    | 1                      |                              |               |  |
|  | _            | Theodore M. King  Date filed (Month, Day,)             |                            |                                   | t Medical E                                 |                                    | 111 Fenn S                            | Jueet, Dan                      | timore, MD 2120                                   |                        |                              |               |  |
| Stat<br>Registra   | .0           | Date fried (Month, Day,                                |                            | In A                              | cod .                                       | 1 ba                               | Kel                                   |                                 |   |                        |                              |               |  |
| DHMH 17 Rev 1/200  | 1            | AFRA   | O ZU                       | ما المال                          | /   | ORIGINA                            | L                                     |                                 |   |                        |                              |               |  |

DHMH 17 Rev 1/2001

State Registrar Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r4 Day Edward Wollenschlager Physician/ 2010 11.4TPM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BACTIMORE WASHINGTOW MEDICAL CENT CIEN BURNIE AMME If Under 1 Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 347–20–0859 1**XX**M 2 □ F Months Days 83 Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b, Count 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Completed by Funeral Director McLean Bloomington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1202 N. Western Avenue 61701 USA items ? permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hyglene. Important: I flem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces?

1XXYes 2 \( \square\$ No Army WWII Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Specify: White 3 XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Masonry Bricklayer 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward ပ John Wollenschlager Helen Fuesling 19a. Informant's Name/Relationship (Type, Print)
Noni Rondeau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 364 Hickery Pt. Rd Pasadena MD 21122 /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4/24/10 1 Burial 2 Cremation 3XXRemoval from State Funks Grove Cemetery McLean, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Victor P. 23 Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Avenue, Baltimore MD 21230  $\omega$ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ HEONIZ OBGRUCINE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner FIBRILLATIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Naturai 5 Pending Accident
Suicide 1 🗌 Yes 2 No Investigation Could not be within 24 hours after death

To the Funeral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and andress of person who completed cause of death (Item 23a) (Type, Print) Hose

Registrar

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 07:20 M **Physician** SHIRLEY WILSON 04 20 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11. | 123, 1934 Hospital University
5. Social Security Number Decialties 9. Birthplace (State or Foreign Country)
Wary Cand 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 M F 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 Xes 2 No altimole Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be n 2121 Funeral death \ 14. Race - American Indian, 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If ten 27 is marked other the "" any Injury or other traum". "natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BOC 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced Year or Dates: Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) nompson ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, WILSON Michelle 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Crematory 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Lix nse 22. Name and Address of Facility tuxera MD 21213 Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death , Heart failure Immediate Cause (Final disease or condition resulting in death) extension Pulmonar **Physician** Due to (or as a consequence of): /Medical Examiner ardiemtof Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent e of) Examiner or Attending Physician: The law requires that the death certificate be executed valvular Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, 08 Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Replairat Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hypertension; 2 No Anemia 2 No 1 ☐ Yes 1∏ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funeral Director: Hospital

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ODDAR

32. Resistrar's Signature

Я

APR 26

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NISHAL PODDAR, 601 South Charles Street, Bothimore

29c. License number

0069440; MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 30 per dvr 9902 4-26-10 vt
State of Maryland / Department of Health and Mental Hygiene
1- State Amend #5, per Inf G903 5/18/10 TT
Certificate of Death

Reg. No. 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month Physician 7:45 PM M 13, Pauline Winchester April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7901 Gough Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 019-12-0536 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Year) Months 1 □ M 2 🖾 F 89 Feb 23, Director 1921 Alabama Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and be notified at MD 1 X Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7901 Gough Street 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1y Yes 2 ☐ If Yes, Give Year or Dates: 2□No1943-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White ģ 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 11nk Elementary/Secondary (0-12) College (1-4or 5+) secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gaspard Williams Belle Elizabeth Jenkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Winchester/son 2010 Copperwood Way; Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 Other (Specify) 21. Signature of Funeral Service Lives ROUALD S 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street wäde Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condit resulting in death) Anemia **Physician** 6 months /Medical Due to (or as a consequence of): Examiner Immune - mediated pancy topenia 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as the ned by the attending detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an performed 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 2 To the I and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 D0051185 15

State Registrar

Colleen Christmas

31. Date filed (Month, Day, 'Year)

TUP

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Deneur

5505 Hopkins Bayview Circle Baltimore, Md. 21224

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 7:30 P M 2010 Wanda Weber Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris Hospice 8. Date of Birth (Month, Day, Ye, une 12, Social Security Numbe Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Maryland Director T946 218-46-5906 63 lune Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21237 USA 6600 Ridge Rd death v 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 K No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) caregiver daycare Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental f Important: If item 27 is marked o Lyle Bruce Albright Yvonne B. Newkirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1314 Grandview Ct; Fallston, Maryland 21047 Tina M. Kyle-Mason/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from St APRIL 4X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Raltimore. Maryland 21201 21. Signatur of Funeral Ser 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest be heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician GLIOBLASTOMA disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 X No Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate:

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate has been signed by ral director, page 2 should be detacl fter this certification, a Il Director:

Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Yes 2 No

1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b. Signature and title

TIMONIUM, MD 21093

2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONES. 31. Date filed (Month, Day, Year)

APR 26

2300 DULANEY VALLEY RD.

hin 24 hours a the Funeral D

within 2

Medical

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SVAM Day Month Year 090 BABY GIRL WELLINGTON 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SPRING CROSS HOSPITAI NER MONTGOMERY 9. Birthplace (State or Foreign Country) MARY LAW D If Under 1 Year | If Under 24 Hrs. 4 Hrs. 8. Date of Birth Min (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 1 F Months Days Hours INFANT 04,18,2010 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Ves 2 No MD MONTGOMERY ROCKY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1305 DRIVE 20852 343 CLUAGET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) NFAN INFANT A N 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TYLER WELLINGTON SHERWIN WARD COUSAR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TYLEA WELLINGTON MOTHER 305 CLAGETT DR ROCKVILLE WD 20821 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5120ther (Specify) in state S Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Ronal<sup>S</sup> Wiregtor Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or con resulting in death) severe win. Due to (or as a consequence of): Sequentially list conditions Due to for as a porsequence of if any leading to in real cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes

**Physician** /Medical Examiner

attending physician certificata be

has

certificate

executed and

P.O. Box 68760

Division of Vital Records,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

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23a. Part shoc

r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinationals.

Baltimore, Maryland 21215-0036

burial-tran as the l use Por signed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Examine Physician/Medical þ Completed

Be completely filled in by the funeral

Certification: To

Medical

29a. Certifiei 29b. Signature and title of certifier

1 Yes

27. Manner of Death

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Natural

25. Was case referred to medical examiner?

24 No

6 □Could not be determined

5 Pending investigation

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an

autopsy

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

26. Place of Death (Check only one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

GLASS 1500 FOREST CLEN RD SILVER SPRING MD 20910 WD JULIE

State Registrar 31. Date filed (Month, Day, Year) -

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 610AM Month Year **Physician** 23 2010 rancos /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SYKESVILLE, MARIAND KIDGE OPPER Carroll County If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreig Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 ☐ M 2 1 F 210-14-0875 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at death with the Marylan 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1260 "natural", or items 23a Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank 0+ 12 sistant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be madeline 2 eorge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Rogers-Pommel Drive, NKESUIlle MD21784 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

20c. Lo 20a. Method of Disposition Department of Important: If it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lementia Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🛣 No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 □ Probably 4 □ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has b lirector, page 2 st performe 21**X**/No 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 (Month, Day Year) Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; / 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R100599

23,20

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death BALTIM Examiner 8. Date of Birth Month, Day 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral 1 ☑ M 2 ☐ F QC Months Davs Hours Director 10d. Inside City Limits "natural", or items 23a or 28a-f show 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland al Hygiene. other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 🗌 Yes 2 🗷 No 10f. Zip Code 10a, Citizen of What Country? 10e. Street and Number 2 2103 UNITED Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes Give 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State 2010 TIMONIUM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Physician DAUS PNEUMONIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 1 Yes 2 g 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES 24b. Were autopsy findings available prior to completion of cause of PERIPHERAL VASCULAR DISEASE 24a Was an autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate has I ISCHEMIC CARDIOMY OF ATHY 1 Yes 2 No 25. Was case referred to medical examiner?

1 ☐ Yes 2 ▼ No Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check West at Lamine business of Schrift and the second of the s within 2 only one)

State Registrar 29b. Signature and title of cert

DANIEUE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MO

APR 26

DHMH 17 Rev 7/2009

6701

32. Regintrar's Signature

D64395

NEHARLES ST, SHITE 4105 BALTIMORE, MD 21204

29d. Date signed (Month, Day, Year)

APRIL 22,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ April 2010 10:05P M Ronald Willson Wayne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chestertown Nursing and Rehab. Kent Chester town If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours (Month, Day, Year) 03/01/1947 Maryland 63 Director 218-48-7224 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a ( Funeral U.S.A. 402 Moranec Road Apt. items death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black White etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 K Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Groundskeeper Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dalton Willson Catherine Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Donovan / Sister 402 Morgnec Road Apt. 4D, Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State any injury or 04/16/2010 Anatomy Gifts Registry Hanover, Maryland 4 X Donation 5 Other (Specify) 21. Signature of Frieral Sirvice licen ice 22. Name and Address of Facility Anatomy Gifts Registry XVI 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mo. Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 □ No 3 □ Probably 4 ■ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. 24 hours after death Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one)

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address orberson who completed cause of death (Item 23a) (Type, Print)

Elizabeth Sipala 119 CN Man

Registrar's Signat

IV

29c. License number

Jalena

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 04/06/2010 SADIE DELANEY BAKER М 6:20 P Medical 4a, Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 6. Sex Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Days Min 05/14/1947 Director 62 241-80-8773 NJ Usual Residence of Decedent 10b. County 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No MD Montgomery Germantown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20503 Alderleaf Terr. 20874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: "natural", Completed 3 Divorced 4 Divorced Black other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Environmental Supervisor Manor Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed h and Mental H 7 is marked ot Sadie Richardson James Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st it of Health a Claudette Baker - niece 1304 Timothy Avenue, Durham, NC 27707 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 injury or Important: I any injury or Cremation Svc 4/12/10 4 Donation 5 Other (Specify) Hanover, MD Signature of Juneral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardio Respiratory Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Uncontrolled Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) End Stage Renal Disease death certificate be executed and that initiated events Due to (or as a consequence of). resulting in death) Last burial-1 ending physician a r use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Day Pregnant at time of death Other (specify) the 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 X Unknown Records. 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy performed? Yes 2X N this certificate 25. Was case referred to medica examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 🛚 No Hospital 1 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? iniury 1 X Natural 5 Pending 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 3 within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٩ 4/6/10 D0067512

Registrar

State

9901 Medical Center Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signat

Madan Sampath Bangalore

12

31. Date filed (Month, Day, Year)

APR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Calvin James Brandenburg 2010 P M 3 2:35 Apr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Prince Georges Laurel 5. Social Security Number . Age (In yrs. last birthday) 70 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 235-56-2931 Davs Hours May 23, Ye Director WV Usual Residence of Decedent 10a, State 10b. County at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified WV Harrison Lost Creek 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PO Box 24 26385 United States 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 Specify: White Year or Dates. UNK 1 ☐ Yes 2XXXNo Specify: "natural" 3 K Widowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Union Hall Carpenters 12th Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Brandenburg Ida Blanche Fiscus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9220 Homestretch Ct. Laurel, MD 20723 Todd Brandenburg (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🖾 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7th Day Bapt. Ch Cem. 4/7/2010 Lost Creek, WV Signature of Funeral Service Lirier-Oueen Funeral Home and Crematory, 1 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ver 5 years Physician/ Chronic Obstructive Pulmonary Disease Medical resulting in death) Due to (or as a consequence of) Examiner secus daily liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transil To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancer of Prostate Completed 1 ☐ Yes 2 ☐ No 3XX Probably 4 ☐ Unknown Arterio Sclerotic Cardio Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: AXX Nursing Home 5 - Residence 6 - Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 ☐ Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) April 6, 2010 D 24721 WJL

State Registrar

ITIVA

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

APR 08 2010

31. Date filed (Month, Day, Year)

Syed Sadiq, MD 14333 Laurel-Bowie Rd. Laurel, MD 20708

32. Registrar's Signature

10-02669 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher Burke State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1906 hrs April 5, 2010 **Medical Examiner** CHRISTOPHER MICHAEL BURKE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Montgomery 20939 Lake Ridge Drive Boyds If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Stete or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Hours 214-15-6738 37 Days 05/07/1972 Director Country) MD 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 'n 10a. State 10c. City, Town or Location 1 Yes 2 No BOYDS 28a-f show MD MONTGOMERY Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she notified at once irector 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20841 靣 21216 CHRISMAN HILL TERRACE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Was Decedent Ever in U.S. must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No 1 Yes Specify: WHITE 1 Yes 2 No specify. 3 Widowed 4 Divorced f Yes, Give Year ≦ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ROOFING FOREMAN 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) MICHAEL J. BURKE LINDA KOONTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 20841 MICHAEL BURKE / FATHER 21216 CHRISMAN HILL TERR., BOYDS, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) or other 1 Burial 2 Cremation 3 Removal from State BARNESVILLE, MARY'S 4/10/2010 CEMET. 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Ser vice License P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medica Death a. Shotgun Wound of Neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as e consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical attending physician for use as the burial UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death 2 past 12 months Pregnant at time of death 5 Other (Specify) icate has been signed by the atte 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 V No 1 Yes certificate 2 🦳 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) å Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes ဥ 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self 1 Natural FOUND: 1 Yes 2 ✔ No Pending To the Funeral Director: completely filled in by the Apr 5, 2010 1849 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 20939 Lake Ridge Drive, Boyds, MD determined (Specify) Parking Lot Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Mon

State

Registrar

DHMH 17 Rev 1/2001

**Assistant Medical Examiner** 

BANKUN

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decede Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give st Examiner 4b. City, Town, or Location of Dea County of Death INRISE SOVERNA STED 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1) 1 □ M 2 🕱 F Hours Min 214-13-2474 Director 94 Mar Maryland Usual Besidence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 41 West McKinsey Road Unit 132B USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 🙀 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Dushane, Jr. Edna Hesson 19a. Informant's Name/Relationship (Type, Print) 21146 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Robert Belt/Husband 43 West McKinsey Road Apt. 304 Severna Park, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 8 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 2010 Baltimore, MD 22. Name and Address of Facility Severna Park Funeral Home Severna Park, MD 21146 Barranco & Sons, 495 Gov. Ritchie P.A. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ OMON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregr 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mo 5 Other (specify) Pregnant at time of death Month Day □ Unknown Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has completed filled in by the funeral director, page 2 performed 2 🗹 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Tes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 00 M ERWIN BLACKMAN Medical 4a.(Pacility Name (if not Institution, give Examiner 4b. City, Town, or Location of Death 4c. County of Death Con Alleno 5. Social Security Number Age (In yrs. last birthday) Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 € M 2 □ F Months Hours 65 **Director** 5.6 126/10 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No MdBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5610 Merville Avenue 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 No If Yes, Give laryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Year or Dates the Medic≖t 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than filed within al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5Plus Business Analyst Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o Edwin Erwin Blackman Doris Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5610 Merville Avenue, Baltimore, Md 21215 Maxine P. Blackman,wife Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/15/2010 Metropolitain Alexandria Va. 21. Signature of Funeral Service Lices 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of <sup>\*</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death JYes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 24 hours after death.

Funeral Director: After this certifics leted filled in by the funeral director. I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 30. Name and address of 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rville Physician/ Month 9:10 2010 WINGSON X Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SIX IS WING Noomico REGIONAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours Director . If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No NURCester New tours 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Un. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No BIK Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NUNR 11042 Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Cather, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Cem rotons Donation 5 Other (Specify) Signa Lre of Funeral Service Licensee 22. Name and Address of Facility 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Director; After this certificate 1 Yes P No Yes P 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Natural 5  $\square$  Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 \_ only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 63199 9/10

State Registrar ENSTERN SHORE DR.

32. Restrar's Signature

SALISBURY MA

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

VOHRA

APR 11

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

|   | 1              | For State Registrar   | ,,,,,   | Cer                               | tificate of  | Death  | R  | eg. No.                          |                        |                                      |       |
|---|----------------|---|---|-----------------------------------|--|--|--|----------------------------------|------------------------|--------------------------------------|-------|
| Physician   |                | . Decedent's Name (First, Middle, L.  |   |                                   |  |  | 2. Date of Dea                             |                                  | 10                     | 3. Time of D                         |       |
| /Medical<br>Examiner  | -              | Esther Bi<br>a. Facility Name (If not institution, gi<br>Chesapeake Wo                                      | erly Clay ve street and number) ods Center  |                                   |  | or Location of Death                                   | April                                      | 4c. County                       | of Death               |                                      | _P    |
| Funeral   | 5              |   | Sex 7. Age (In yrs. 1 M 24 F 81   | last birthday)<br>Yrs.            | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.                                       | 8. Date of Birth<br>(Month, Day<br>Feb. 12 | , Year)<br>1929                  | Cour                   | place (State or<br>ntry)<br>y Land   | Fore  |
| Director  |                | Jsual Residence of Decedent   |   |                                   |  |  | 100. 12                                    | , - , - , - ,                    |                        |                                      |       |
| a-f show  |                | MD 10b. County Dorch  | ester 10c. Cil  | y, Town or La                     |  | New Market   |  |                                  |                        | 10d. Inside City<br>1 ☐ Yes          |       |
| ifer death with the Man relams 23a or 28a-f sh incrnust to rutilled   | מו ה           | Oe. Street and Number<br>5633 Springdal   | e Road  |                                   | 10f. Zip Code  | 21631  |  |                                  | ISA                    |                                      |       |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or othar traumatic evant, title Medical Examiner must be notified at once.  To Re Completed by Funeral Director | 2              | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced                                   | 12. Was Decedent Ever in U<br>Armed Forces?<br>1  Yes 2 No<br>If Yes, Give<br>Year or Dates:      | 1                                 | Was Decedent of<br>If Yes, specify Cul<br>1 ☐ Yes 2 🔀 No | Hispanic Origin? (Spoan, Mexican, Puerto<br>o Specify: | ecify Yes or No-<br>Rican, etc.)           | 14. Rac<br>Blac<br>Specify       | ck, White,             | can Indian,<br>etc.<br>hite          |       |
| d 2 should be filed within 72 hours aft this and Mantal Hygiends 27 is marked othar than "natural", or traumatic evant, 11th Medical Exam To Re Completed by E  | nataidi        | 15. Decedent's (Specify only highest g  |   | (Give                             | DO NOT use retin   | during most of work<br>ad)                             | king                                       | 16b. Kind of B                   |                        |                                      |       |
| od with   |                | 11  |   |                                   | home   | maker  | (F) - A A (-)                              |                                  | n hor                  | me<br>—————                          |       |
| weld be filk<br>Mental Hy<br>arked oth<br>atic evant  | ۵<br>0         | 17. Father's Name <i>(First, Middle, Las</i><br>William Bierly  |   |                                   |  | Minnie   | Kuhn                                       |                                  |                        |                                      |       |
| nd 2 shoulth and N  |                | 19a. Informant's Name/Relationship<br>Diana Jackson   | (Type, Print)<br>daughter   | 19b. Mailii<br>2206               | ng Address <i>(Stree</i><br>Church                       | ot and Number or Rus<br>Creek Rd.                      | a <i>l Route Numbe</i><br>, Cambri         | r, City or Town,<br>dge, MD      | , State, Zip<br>) 21   | p Code)<br>613                       |       |
| rmit. Pages t a partment of Hes portant: If item y injury or otha cea.  | Ī              | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec                          | □Removal from State   | cemetery, crei                    | osition (Name of<br>matory or other pl<br>ity Chur       | chyard 4,  |  | Church                           | Cre                    | ek, MD                               |       |
| permit. Departmitmportal  |                | 21. Signature of Funeral Service Lice   | ensee   |                                   | 2. Name and Addi   | ress of Facility T]<br>t St., Car                      | nomas Fu<br>mbridge,                       |                                  | Home 1<br>1613         | P.A.                                 |       |
|   | 1              | 23a. Partit Enter the disease, or co<br>shock, or heart failure. List on                                    | mplications that caused the dea   | th. Do not en                     | ter the mode of dy                                       | ring, such as cardiac                                  | or respiratory ar                          |                                  |                        | Approximate<br>Interval Betw         | veen  |
| Physician <sup>1</sup>  |                | Immediate Cause (Final disease or condition   | End   | Stag                              | e De   | mentic   |  |                                  |                        | Onset and D                          | eau   |
| /Medical<br>Examiner  |                | resulting in death)   | Due to (or as a consec  | quence of):                       |  |  |  |                                  |                        |                                      |       |
|   | e e            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b   | quence of):                       |  |  |  |                                  |                        |                                      |       |
| ansit   | Examin         | that initiated events   | c   |                                   |  |  |  |                                  |                        |                                      |       |
| rificate be executed rificate be executed ng physician and ras the burial-transit   |                | resulting in death) Last  | Due to (or as a conse   | quence of):                       |  |  |  |                                  |                        |                                      |       |
| entificat<br>ling phy<br>e as th  | Medical        | IF FEMALE:  | O20 If you guitaging of program   | unnou.                            |  |  |  | 224 D                            | ate of deliv           | uon.                                 |       |
| requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit   | Physician/     | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown                               | 23c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | al death 3[                       | □Ectopic pregnan □ Other (specify)                       | cy   |  | 1                                | onth                   |                                      | 'ear  |
| wrequires that the de been signed by the should be detached   | 2              | Part II. Dther significant condition  | s contributing to death but not re  | sulting in the u                  | underlying cause ç                                       | given in Part I.                                       | 23e. Did to                                | obacco use con                   |                        | the cause of do                      |       |
| 2 s b   | Completed      |   |   |                                   |  |  | 24a. Was<br>autor<br>perio<br>1 🗆 Yes      | an 24b.                          | death?                 | topsy findings a<br>completion of ca | ivail |
| lan: T  | Be             | 25. Was case referred to medical examiner?  |   |                                   |  | 26. Place of Dea                                       |  |                                  |                        |                                      | _     |
| Physic<br>This ce   | 9              | 1 Yes 2 No  | Hospital: 1 Inpatient 2   | 28b. Time of                      | int 3 DOA  |  | ome 5 Residence                            | dence 6 Ot                       |                        | cify)                                |       |
| nding<br>tth.<br>:: After<br>e fune   | ation          | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga   | 28a. Date of Injury<br>(Month, Day Year)  | Injury                            |  | lork?<br>□Yes 2□No                                     |  |                                  |                        |                                      |       |
| To the Hospital or Attanding Physician: The law requires twithin 24 hours after death.  To the Funaral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be   | Certification: | 3 Suicide 6 Could no determin   |   | home, farm, st                    | treet, factory, offic                                    | 9  | 28f. Location (.<br>City or To             | Street and Num<br>wn, State)     | iber or Ru             | ral Route Num                        | ber,  |
| Hospite<br>24 hours<br>Funara<br>tely fille   | ledicai C      | (Check only 2 Medical Ex  | Physicien: To the best of my kr<br>caminer: On the basis of examin                                | nowledge, dea<br>nation and/or in | th occurred at the                                       | time, date and place<br>y opinion, death occu          | , and due to the<br>irred at the time,     | cause(s) and m<br>date and place | nanner as<br>, and due | stated.<br>to the cause(s            | )     |
| o the nithin 2 o tha omplet   | Med            | one) 29b. Signature and title of certifier  | and manner stated.  |                                   | 29c. Lice  | nse number   |  | 29d. Date sign                   | ed (Monti              | h, Day, Year)                        |       |
| + × + ö   |                | ▶ No  | wy Mo   |                                   | D  | 47924  |  | 4.6                              | .10                    |                                      |       |
| 3   |                |   | no completed cause of death (lite   | em 23a) (Туре<br>В УКЛ            | o, Print)  | CAMBRIL  | DGE .                                      | MD 21                            | 613                    |                                      |       |
| State   | e              | 31. Date filed (Month, Day, Year)   | 32 Registrar's Sign   | nature                            | are  |  |  |                                  |                        |                                      |       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:50 P M Raymond Patrick Cleary April 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death National Lutheran Home Rockville Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpie Country) York Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 🗆 F Min. Hours 94 Yrs. Director 075-10-4851 Usual Residence of Decedent show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Montgomery Rockville 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 Dunster Rd 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 10/ 11. Marital Status 2 No 1942-14. Race - American Indian. Black, White, etc. by I 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examinant in 1 XYes If Yes, Give Baltimore, Maryland 21215-0036 1946 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Westchester Community Shipping & Receiving Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Theodore Cleary Viola Tompkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Dougherty/ Daughter 616 Firehouse Lane, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Crownsville Vet.Cem. 04/07/2010 Crownsville, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Crem. 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the dise shock, or leart failure se, or complications that caused the death. List only one caus — each line. To not enter the mode of dying, such as car, or respiratory arrest, Immediate cause (Find disease or condition Onset and Death ysician/ ledical resulting in death) ∟xaminer Sequentially list conditions, if any, leading to immediate Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnanc 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Ves 2 LN6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner de ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Latural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is a control of the cause of examiner and the control of the cause of examiner and the control of the cause of examiner and the control of the cause of examiner and the cause 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 26033 Ridge Road;

62. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Karesh, M.D

1

31. Date filed (Month, Day, Year)

License number

Damascus,

MD 20872

| Amend #18 per FD  | 4 45 45  | int in Black Indelible In  | •   | -  |
|---|--|--|---|--|
| aa oo health dept   | 1 – 12 – 10 KAT1 State of N<br>1 – State<br>Registrar  | laryland / Department of I<br>Certificate of L   | Conth   | 2010 12865   |
|   | Registrar  1. Decedent's Name (First, Middle, Last)  | Certificate of L   | 2. Date of Death  | 3. Time of Death   |
| Physician/<br>Medical   | PAULINE  | (APRIC   | OTTI APRIL  | 5 ZOIO 600A M  |
| Examiner  | 4a. Facility Name (if not institution, give street and number) SUN RISE ASSISTED   | LIVING Seve  | r Location of Death PARK  | 4c. County of Death  Anne Arvoc                                      |
| Funeral<br>Director   | 5. Social Security Number 6. Sex 1 ☐ M 2 🖾 F 7. A  | ge (In yrs. last birthday)  88 Yrs. If Under 1 Year Months Days                            | Hours Min. 8. Date of Birth (Month, Day, Ye                                       | 9. Birthplace (State or Foreign Country) Ohio                        |
| show at   | Usual Residence of Decedent           10a. State         10b. County   | 10c. City, Town or Location  |   | 10d. Inside City Limits  |
| Maryla<br>28a-f s<br>lotified   | MD Anne Arundel  | Severna Park   |   | 1 ☐ Yes 2 🔀 No   |
| leath with the Maryland items 23a or 28a-f sho er must be notified at Funeral Director  | 303 St. Ives Drive   | 10f. Zip Code  | 21146   | g. Citizen of What Country? USA                                      |
| 0 1.5   | 11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Armed Forces  1 Yes, Give Year or Dates.   | Ever in U.S.  13. Was Decedent of H If Yes, specify Cuba  1  Yes 2  No                     | ispanic Origin? (Specify Yes or No-<br>an, Mexican, Puerto Rican, etc.)  Specify: | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White  |
| 215-(   | 15. Decedent's Education (Specify only highest grade completed)  | 16a. Decedent's Usual Occup<br>(Give kind of work done of<br>life, DO NOT use retired)     | eation 16<br>during most of working   | Sb. Kind of Business Industry  |
| d 212<br>led withir<br>Hygiene<br>other the<br>ent, the<br>Be Co  |  | Homema Homema  |   | Home   |
| and<br>be filed<br>antal H<br>ked ot<br>c even  | 17. Father's Name (First, Middle, Last)  George Edward Crosby  |  | 18. Mother's Name ( <i>First, Middle, Mai</i><br>• <b>Mary - Ja</b>               | ne Mills Mary Jennie   |
| altimore, Maryland 21215-0036 rmit. Page 1 and 2 should be filed within 72 hours after partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or y injury or other traumatic event, the Medical Examice.  To Be Completed by  | 19a. Informant's Name/Relationship (Type, Print) Marisa Capriotti/Daughter   | 19b. Mailing Address (Street 282 Greenle   | and Number or Rural Route Number, Ci<br>af Circle Arnold                          | ty or Town, State, Zip Code)  MD 21012                               |
| Baltimore, M permit. Page 1 and 2 s Department of Health a Important: If item 27 i any injury or other tra  | 20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State   | 20b. Place of Disposition (Name of   | Date 20   | Dc. Location - City or Town, State                                   |
| Itim  | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Ligense   | Metro Crematory  | 2010  | Baltimore, MD  |
| Bal<br>permii<br>Depar<br>Impor<br>any in   | 21. Signature of the Court   | Barranco<br>495 Gov.   | ss of Facility<br>& Sons, P.A. Seve<br>Ritchie Hwy. Seve                          | rna Park Funeral Home<br>rna Park, MD 21146                          |
| Physician<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lis Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as | ed the death. Do not enter the mode of dyinge.   | <del>-</del>  | Interval Between   |
|   | Sequentially list conditions, if any, leading to immediate Due to (or as   | a consequence of):   |   |  |
| executed lan and land-transit   | cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as  | a consequence of):   |   |  |
| a iar e   | d  |  |   |  |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftending physician completed filled in by the funeral director, page 2 should be detached for use as the burit Medical Certificate: To Be Completed by Physician/Medical |  | 2 ☐ Fetal death 3 ☐ Ectopic pregnand at time of death 5 ☐ Other (specify) _                | су  | 23d. Date of delivery<br>Month Day Year                              |
| S, P.O ires that the signed by discreta   | Part II. Other significant conditions contributing to death  HYPEIZTENSION   | but not resulting in the underlying cause gi   | ven in Part I. 23e. Did tobac   | cco use contribute to the cause of death?                            |
| Records, P. The law requires the rate has been signed page 2 should be d  | ANEMIA   |  | 24a. Was an autopsy   | 24b. Were autopsy findings available prior to completion of cause of |
| Rec<br>The la   | BIZ DEFICIENCY   |  | performe<br>1  Yes 2  | d?/ death?   |
| Vital hysician: nis certific I director,  | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpa   | 26. Pi   | er: 4   Nursing Home 5   Residence  | te 6 Other (Specify) 1.1 VIVIa                                       |
| n of \ding Phy h. After thiir funeral cate: T   | 27. Manner of Death  1 Natural 5 Pending (Month, D   | ury 28b. Time of 28c. Injury work  | y at 28d. Describe how  |  |
| ivision of or Attending P after death. Director: After tin by the funera  |  | jury - At home, farm, street, factory, office tc. (Specify)                                |   | et and Number or Rural Route Number,<br>state)                       |
| Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s Medical Certificate: To Be Comp   | (Check 2 Medical Examiner: On the basis of   | of my knowledge, death occured at the time examination and/or investigation, in my opinion | on, death occurred at the time, date and p  | place, and due to the cause(s) and manner stated.                    |
| To the within To the comple   | only one) 3 LJ Certifying Nurse Practioner: To the 29b. Signature and title of certifier   | e best of my knowledge, death occurred at the 29c. Licens                                  |   | use(s) and manner as stated.  I. Date signed (Month, Day, Year)      |
|   | 30. Name and address of person who completed cause of  | death (Item 23a) (Type, Print)   | 16360 1   | APEILS, 2010   |
| CHAO  | MICHAEL A. ANCREM MO   |  | HMAYM/ILLERSVI  | 4eM021108  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)  APR 0 8 2010  32. Refist  | rar's Signature  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) A PIZ **Physician** 2010 A Bette E. Chambers 10 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGIN ES HOSPITAL None If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/21/1927 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🗗 F 82 MD 220-24-3359 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marcal Event in the results of any once. 10a State 10b. County 1 ☐ Yes 2 No Director Howard Ellicott City MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4119 Old Columbia Pike 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White <u>Ş</u> 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Interior Decorator Interior Decorating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Lee Baker ပ Harry S. Eklof 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alisa Walterhoefer - daughter 3674 Park Avenue Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Grove Cemetery 04/16/2010 Glenwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Shem Ollms Vi 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death S Immediate Cause (Final disease or condition resulting in death) CANCER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be execu Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ Yo Year 4 ☐ Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>Ş</u> REMAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 1 1 16 1 ☐ Yes Division of Vital Hospital or Attending Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LANICHHANE, DIMAN 900 S. 900 S. CATON AV BALTIMORE, MD 21229 1 31. Date filed (Month, Day, Year) APR 12 2010 State gark. Registrar

CHAMID

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 April Physician/ 5:40 A M 8 Jennifer Chang YenqHua Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Montgomery 12216 St. James Road Birthplace (State or Foreign Country)
 Taiwan Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🖾 F Months Days Hours Jan 4, 1959 51 **Director** 312-90-2943 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12216 St. James Road 20854 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed Asian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ္ Tsun-Ming Chang Jen-Ming Lin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Potomac, Maryland 20854 Shyh-Ing Jang/husband 12216 St. James Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State inal Journey Crematory 4/10/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signative of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 thomas vanita Clarksville. M00957 Beverly L. Heckrotte, P.A. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Ducito (or as a consequence of): and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the Funeral Director: After thin pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛮 Natural 5 Pending death. 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 24 within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tith of o April 9, 2010 D35635 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 12 Joseph Kaplan, M.D. 18111 Prince Philip Drive, Suite 327 Olney, Maryland 20832 Date filed (Month) 32. Registrar's Signatur 1 2 201 State Registrar

Please Type or Print in Black Indelible Ink, Ensura All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:14 P M LEE CUMMINGS 12, 2010 DAVID April /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Easton Talbot Hospice House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, ) Aug. 13, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) Year) 939 **Funeral** Months 217-36-2205 70 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exemples must be notified at 1 ☐ Yes 2K No Director MD Dorchester Cambridge the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21613 United States 700 Twin Point Cove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Allined Toles:

1 ☐ Yes 2 ☐ Not 56 - 59

If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify. White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Waverly Press permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglent Important; If item 27 is marked other tha any nijury or other traumatic event, Ital once. Pressman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Sewell Cummings Messick James Nicholas Cummings ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 700 Twin Point Cove Rd., Cambridge, MD 21613 Mary E. Cummings/Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern SH. Veterans Cem. 04/16/10 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licenses Michael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PROSTATE CANCER YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): SYNDROME Examiner 8 months MYELODYSPLASTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the deatl certificate be executed siclan and burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>Ş</u> sign be 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 1 ☐ Yes **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 tother (Specify) hospice 1 ☐ Yes 2 🔼 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide tiring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 D3988 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

David H. Smith, M.D., 8221 Teal Dr., Suite 302, Easton, MD 21601

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2010 Joseph S. Capece 18 2010 4c. County of Death Apri /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore sedal -ranklin 0 Mare 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth 09-04-1955 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) **Funeral** Hours Days 1 🕅 M 2 🗆 F 54 210-50-6447 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan it we must be notified at once. 1 Nes 2 No Haure de Grace Maryland Harford 10g. Citizen of What Country? United States of America 10f. Zip Code 21078 10e. Street and Number 871 Ontario Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11 Marital Status Black, White, etc White 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes Give ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Resignation Owner 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Dominick Capece Gilda Mascucchini ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Keshvijn Capece (Mino) 871 Ontario Street, Havre de Grace, Maryland 21078 (wine) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20a. Method of Disposition Havre de Grece, Maryland 04-21-2010 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) P.A. 21078 22. Name and Address of Facility Zellman Funeral Home 21. Signature of Panyfal Sorvi 123 S Washington St. Havre de Grace Howarend Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Cancer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed 1 □Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Department 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined filled in by 4 Homicide 1.7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print)

DIL

within 2 To the I

29c. License number

Res 00000

29d. Date signed (Month, Day, Year)

10-02786 John Paul Daye Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| onn Paul Daye  |   | 1- For State   | ate of Maryla                           |                              | paπm<br>Certific     |                           |                  |                            | Menta                    | аі Ну          | _                   |                | 20                    | 10                           | 129                                  | 271         |
|--|---|--|---|------------------------------|----------------------|---------------------------|------------------|----------------------------|--------------------------|----------------|---------------------|----------------|-----------------------|------------------------------|--------------------------------------|-------------|
| Physici  | an/   | Registrar  1. Decedent's Name (First, Midd   | le,Last)                                |                              |                      |                           | Dout             |                            |                          |                | 2. Date of Dea      | Reg. No<br>ath | <u> </u>              | 1 0                          | 3. Time of Deat                      | ) / (<br>th |
| Medical Exam   | iner  | Juin raul I  |   |                              |                      |                           |                  |                            |                          |                | Month<br>April 9, 2 | Day<br>010     | Year                  |                              | 0817 hrs                             |             |
|  |   | 4a. Facility Name (if not institution  |   | umber)                       |                      | 4                         | -                |                            | ocation of               | Death          |                     |                | c. County of          |                              |                                      |             |
|  |   | Peninsula Regional M   |   |                              |                      |                           | Salisl           |                            |                          |                |                     |                | Wicomic               |                              |                                      |             |
| Funeral<br>Director  |   | 5. Social Security Number  | 6. Sex                                  | 7. Age (In y                 | rs. last bir         | thday)                    | If Unde          | s Days                     | If Under<br>Hours        | 24Hrs.<br>Min. | 1                   |                |                       | Canada                       | nplace (State or                     |             |
| Director   |   | 215-90-8295  | 1 X M 2 F                               | 42                           | _                    | Yrs.                      |                  | 34,0                       |                          |                | 08/21               | /19            | 67                    | Cou                          | Maryla                               | and         |
| any  |   | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. 0                       | City, Town           | or Location               | on               |                            |                          |                |                     |                |                       |                              | 10d. Inside City                     | / Limits    |
| * .  | _   | Maryland Wicomi  |   |                              | •                    | rson                      |                  | ~                          |                          |                |                     |                |                       |                              | 1 Yes 2                              |             |
| daryland<br>28a-f show<br>1 at once.   | cto   | 10e. Street and Number   |   |                              | Га                   | 15011                     | 10f. Zip         |                            |                          |                | <u>-</u>            | 10g. Cit       | izen of Wha           | t Coun                       |                                      | E.E./       |
| with the Maryland ns 23a or 28a-f she be notified at once  | Director  | 5958 Forest Gi   | ove Road                                |                              |                      |                           | 2                | 1849                       |                          |                |                     |                | USA                   |                              | ,                                    |             |
| with ms 23.  | ıra   | 11. Marital Status   | 12. Was Dec                             | cedent Ever i                | n U.S.               | 13. Was                   | s Decede         | nt of Hisp                 | anic Origin              | n? (Spe        | cify Yes or No      | 0-             |                       | Americ                       | an Indian, Black                     | k,          |
| death or ite   | Funeral   | 1 X Never Married 2 M  | arried Armed F                          | orces?<br>2 X N              | 0                    | If Ye                     | es, specif       | y Cuban,                   | Mexican, F               | Puerto F       | Rican, etc.)        |                | White,                | etc.                         |                                      |             |
| affer liner  |   |  | orced If Yes, Give Yea<br>or Dates:     |                              |                      |                           |                  | s 2 X No specify:          |                          |                |                     |                | specify: White        |                              |                                      |             |
| hours  | per   | 15. Decedent's Education (Spe  |   |                              | ) 16a                | Decedent<br>during mo     | s Usual          | Occupation<br>king life. [ | n (Give kir<br>DO NOT u: | nd of wo       | ork done<br>d)      | 16b.           | Kind of Bus           | iness/Ir                     | idustry                              | 10          |
| 36<br>nin 72<br>s.<br>than '   | ple   | Elementary/Secondary (0-12)  | College (1                              | 1-4 or 5+)                   | ,                    | nstal                     | 1100             |                            |                          |                |                     |                |                       |                              |                                      |             |
| d with   | Completed by  | 17. Father's Name (First, Middle,  | Last)                                   |                              |                      | iista.                    | TTEL             | 18                         | 3.Mother's               | Name (         | First, Middle.      |                | arpet                 |                              |                                      |             |
| MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thin and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once   | Be (  | Harvey Daye  |   |                              |                      |                           |                  |                            |                          |                | Davis               |                | ,                     |                              |                                      |             |
| D 21<br>should<br>and Mer<br>7 is man  | ဥ   | 19a. Informant's Name/Relations  | hip (Type, Print )                      |                              |                      |                           |                  |                            |                          |                | ral Route Nu        |                |                       |                              |                                      | - 8         |
| MC 2 sladth ar m 27  |   | Nellie Moats/Mo  | ther                                    |                              |                      |                           |                  |                            |                          |                | , Pars              | _              |                       |                              |                                      |             |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten injury or other traumatic event, the Medical Examiner must   |   | 20a. Method of Disposition  1 Burial 2 Cremation   | 3 Removal fr                            |                              | b. Place o<br>cremat | of Disposit<br>ory or oth |                  |                            | etery,                   |                | Date                | 20c.           | Location - 0          | City or                      | own, State                           |             |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or oth  |   | 4 Donation 5 Other S   | pecify:                                 |                              | remato               | -                         |                  |                            |                          | /13            | /2010               | De             | elmar,                | De                           | laware                               |             |
| Ball<br>Sermit<br>Separt<br>Impor  |   | 21. Signature of Funeral Service   | Li ensee                                | 00,                          | )                    | 22. Na<br>Ze              | ame and.<br>11er | Address o                  | of Facility              | Home           | . P. (              | ). B           | ox 31                 | 71                           |                                      |             |
| Physician  | 1   | Za. P I. Enter the disease, or   | complications that c                    | aused the de                 | ath. Do no           | 1121                      | 2 01             | d Oc                       | ean (                    | City           | Road,               | Sa.            | lisbu                 | у,                           | MD 2180 Approximate Is               |             |
| /Medical   |   | Milure. List only one caus   | on each line                            |                              |                      |                           |                  |                            |                          |                |                     | oot, or i      | ook, or rica          |                              | Between Onso<br>Death                | et and      |
| Examiner   |   | Immediate Cause (Final disease<br>or condition resulting in death)                                 | a. Ather Due to (or as a                |                              |                      | carc                      | 110V2            | iscui                      | ar d                     | ısea           | se                  |                |                       | _                            |                                      |             |
|  | L   | Sequentially list conditions,  | b                                       |                              |                      |                           |                  |                            |                          |                |                     |                |                       |                              |                                      |             |
|  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |  |   |                              |                      |                           |                  |                            |                          |                |                     |                |                       |                              |                                      |             |
| P  | хап   | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): |   |                              |                      |                           |                  |                            |                          |                |                     |                |                       |                              |                                      |             |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transit |   |  | d                                       |                              |                      |                           |                  |                            |                          |                | <del></del>         |                |                       |                              |                                      |             |
| <b>50,</b> tte be exhysician   | ledical   | UNPENDED   | AMENDED 23                              | a,27,p                       | er M                 | E G90                     | 3 5/             | 18/1                       | 0 TT                     |                |                     |                |                       |                              |                                      |             |
| OX 6876 leath certificate attending phy  | ician/M   | IF FEMALE:<br>23b. Was decedent pregnant in th   | 200. II y 00,                           | outcome or pr                | regnancy<br>2        |                           | al death         | 3                          | Ectopic p                | regnand        | cv                  | 23             | d. Date of d<br>Month | elivery<br>Da                | ay Yea                               | ar          |
| Box 687; death certifice the attending p   | icia  | past 12 months?  | 4 Pregn                                 | ant at time of               |                      |                           | er (Spec         |                            | ]=                       |                | -3                  |                | monar                 |                              | .,                                   | 41          |
| O. Boy<br>tt the death<br>by the att<br>ached for  | Physi   |  | 9 Unkno                                 |                              |                      |                           |                  |                            |                          |                |                     |                |                       |                              |                                      |             |
| ires that the signed by I be detach  | by  | Part II. Other significant conditi   | ons contributing to                     | death but no                 | ot resulting         | g in the un               | nderlying        | cause giv                  | en in Part               | I.             |                     | _              |                       | _                            | ne cause of deat                     |             |
| ds, l  |   |  |   |                              |                      |                           |                  | _                          |                          | _              | 3-2-2-2-2           |                | 1-01-10-10            |                              | , ,                                  |             |
| cords law require has been so 2 should   | ompleted  |  |   |                              |                      |                           |                  |                            |                          |                | 24a. Was<br>autop   |                | pri                   | ere auto<br>or to co<br>ath? | ppsy findings av<br>mpletion of cau: | se of       |
| tal Records, cian: The law requir certificate has been sector, page 2 should   | 힝   |  |   |                              |                      |                           |                  |                            |                          |                | 1 Yes               |                |                       | Yes                          | 2 🔲 1                                | No          |
| Vital Rec<br>ysician: The<br>his certificate<br>director, page   | a   | 25. Was case referred to medical examiner?   | I I a a sit a l                         | enstiont 2                   | <b>4</b> 50/0        |                           |                  | To                         | f Death (C               |                | <del></del>         |                |                       |                              |                                      |             |
| of Vital<br>ling Physician<br>After this cert<br>funeral directo   | 음   | 1 Yes 2 No<br>27. Manner of Death  | 28a. Date                               | npatient 2                   |                      | Itpatient                 |                  | Bc. Injury                 |                          | <del>_</del>   | Home 5 8d. Describe |                |                       | Other:                       |                                      |             |
| ion c<br>tending<br>eath.  | 뎚   | 1 X Natural 5 Pend   | (Month,                                 | , Day,Year)                  |                      |                           | ,,               |                            | s 2 N                    | - 1            | od. Describe        | 1101111111     | ary occurred          | •                            |                                      | - 1         |
| Division as of a Division as after death.  | ertification:   |  | tigation 28e. Place                     | e of Injury - A              | t home, fa           | rm, street                | , factory,       | office buil                | lding, etc.              | 2              | 8f Location (       | Street a       | nd Number             | or Rura                      | Il Route Number                      | r, City     |
| Divi   | er.   | 4 Homicide deter   | mined (Specify)                         |                              |                      |                           |                  |                            |                          |                | or Town, S          |                |                       |                              |                                      |             |
| Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b  | Sa C  | 29a. Certifier 1 Certifying Pt   | ysician: To the bes                     | t of my knowl                | edge, dea            | ith occurre               | ed at the        | time, date                 | and place                | e, and di      | ue to the caus      | se(s) an       | d manner a            | s stated                     | 1                                    |             |
| To the Howithin 24 h To the Fur  | Medical   |  | miner: On the basis of<br>and manner st | of examination<br>tated      | n and/or ir          | nvestigatio               | on, in my        | opinion, d                 | leath occur              | rred at t      | he time, date       | and pla        | ace, and due          | to the                       | cause(s)                             | _3          |
|  | Σ   | 29b Signature and title of certifie  | $\bigcap$                               | 0                            |                      |                           |                  | License r                  |                          |                |                     | I .            |                       |                              | h, Day, Year)                        |             |
|  | ļ   | total la   | - 1 LOK                                 | Vol.                         | ~                    |                           |                  | O.C.M.                     | .E.                      |                |                     | Apri           | il 10, 201            | U                            |                                      |             |
|  | ļ   | <ol> <li>Name and address of person<br/>Patricia Aronica-Pollal</li> </ol>                         |   | e of death (It<br>ant Medica |                      | iner                      | 111 Pa           | nn Stre                    | et Ralti                 | more           | MD 2120             | 1              |                       |                              |                                      |             |
|  | ate   | 31. Date filed (Month, Day, Year)  |   | gist ar's Sign               |                      |                           | ak               |                            | Ct, Daill                | more,          |                     | '              |                       |                              |                                      |             |
| Reaist   | e le  | ADO  |   | A                            |                      | 1. 4                      | BALLEY.          |                            |                          |                |                     |                |                       |                              |                                      | - 1         |

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|   |               | 1 _ For  | State of Marylar  | •                                |  |                                      | d Mental Hy                               | giene  |  |
|---|---------------|--|---|----------------------------------|--|--------------------------------------|---|--|--|
|   |               | Registrar  |   | Ce.                              | rtificate of                             | Death                                |   | Reg. No.   | 1287   |
| Physic  | cian          | 1. Decedent's Name (First, Middle, L   |   |                                  |  |                                      | 2. Date of Dea<br>Month                   | Day Year   | 3. Time of Death                                   |
| /Med<br>Exam  |               | Dorothy Dyke  4a. Facility Name (If not institution, g                       |   |                                  | 4b. City, Town, o                        | or Location of De                    | April 6                                   | 4c. County of Dear   | 11:30 P M  |
|   | mer           | Arcola Health &  |   | n Ctr.                           |  | er Spri                              |   |  | gomery   |
| Funera  | 1             | Social Security Number     6.  | Sex 7. Age (In yrs.   | last birthday)                   | If Under 1 Year<br>Months Days           |                                      | Irs. 8. Date of Birt                      | h 9. Bir   | hplace (State or Foreign untry)                    |
| Directo   | r             | 157-01-2117  | 1□M 25XF 92   | Yrs.                             | Dayo                                     | , louid                              |   | 5, 1917  | Virginia   |
| land ow   |               | Usual Residence of Decedent  10a. State 10b. County                          | 10c. Ci   | ty, Town or Lo                   | ocation                                  |                                      |   |  | 10d. Inside City Limits                            |
| Mary<br>I-f sh  | ţ             | Maryland Baltim  | ore County  |                                  |  | Owings :                             | Mills                                     |  | 1 XIYes 2 ☐ No                                     |
| th the<br>or 28g  | Director      | 10e. Street and Number   | -1  |                                  | 10f. Zip Code                            |                                      |   | 10g. Citizen of What Co  | untry?   |
| be filed within 72 hours after death with the Maryland ntal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Madigal Examirer must be retified at   |               | 11 Kentbury (  | Court   |                                  | , , , , , , , , , , , , , , , , , , ,    | 21117                                |   | Unit   | ed States  |
| er dea<br>Items   | Funeral       | 11. Marital Status   | 12. Was Decedent Ever in U.<br>Armed Forces?                        | .S. 13.                          | Was Decedent of I<br>If Yes, specify Cub | Hispanic Origin?<br>an, Mexican, Pu  | (Specify Yes or No-<br>lerto Rican, etc.) | 14. Race - Ame<br>Black, White                                 |  |
| ours after  | by F          | 1 Never Married 2 Married 3 Widowed 4 Divorced                               | 1   | ļ                                | 1 □Yes 2 🗷 No                            | Specify:                             |   | Specify: B1  | ack  |
| 2 hou   | ted           | 15. Decedent's I   | Education   |                                  | dent's Usual Occup                       |                                      |   | 16b. Kind of Business/   | Industry   |
| hin 7:  | nple          | (Specify only highest g  | rade completed)  College (1-4or 5+)                                 | (Give                            | kind of work done<br>DO NOT use retire   | during most of v<br>d)               | working                                   |  |  |
| ed will<br>ygien<br>yer th  | Completed     |  | 5+  | Pe                               | ersonnel                                 |                                      |   | Governme   | ent  |
| d be file   | a             | 17. Father's Name (First, Middle, Las  | ·   |                                  |  | 18. Mother's N                       | Name (First, Middle,                      | ,  |  |
| hould<br>d Mei<br>marke   | ္             | WIIIIam  19a. Informant's Name/Relationship                                  | H. Dykes  | 40h Maili                        | 8 dd /Ot                                 |                                      | Ola B. P                                  |  | 7-0-4-1  |
| Daritimore, Mari yialin ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examiner must be notified at once. | 1 3           | Virgil H. Davis,   |   | 1                                | -  |                                      |   | er, City or Town, State, $11\mathrm{s}$ , $\mathrm{Md}$ . $21$ |  |
| S 1 ar  |               | 20a. Method of Disposition   | 20b. F  | Place of Dispo                   | sition (Name of                          | 1                                    | Date                                      | 20c. Location - City or  |  |
| Pages<br>nent of<br>nnt: If ite   |               | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec                    | - Heriloval Itolii State  | Har<br>emoria                    | mony                                     | Ap<br>20                             | oril 13,                                  | Landover,  | Marvland   |
| Dalli<br>permit.<br>Departr<br>Importa<br>any Inju  | Ŕ             | 21. Signature of Funeral Service Lice  |   | A 2                              | 2. Name and Addre                        | ess of Facility                      |   | ineral Home  |  |
| D 90 E 8 9  | şi.           | DWO Still  | 7670074-11  | AT                               | 4001 Benn                                | ning Rd.                             | NE Wash                                   | ington, DC   | 20019  |
|   |               | shock, or heart failure. List onl  | mplications that caused the deat<br>y one cause on each line.       | h. Do not en                     | ter the mode of dyi                      | ng, such as card                     | diac or respiratory ar                    | rest,  | Approximate<br>Interval Between<br>Onset and Death |
| Physician /Medical  | _             | Immediate Cause (Final disease or condition resulting in death)              | a. MULTIPLE   |                                  | RE BRO                                   | VASGU                                | LAR AC                                    | CIDENTS  | YEARS  |
| Examiner  | _             |  | Due to (or as a conseq  | uence of):                       |  |                                      |   |  |  |
|   | ē             | Sequentially list conditions,  | b   | uenec of).                       |  |                                      |   |  |  |
| ecutec<br>nd<br>ransit  | Examiner      | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | c   |                                  |  |                                      |   |  |  |
| or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the buriat-transit.  |               | resulting in death) Last   | Due to (or as a conseq  | juence of):                      |  |                                      |   |  |  |
| physi<br>the b  | dical         |  | <b>d</b>  |                                  |  |                                      |   |  |  |
| eath certific<br>attending p  | ₩             | IF FEMALE:   | 23c. If yes, outcome of pregna                                      | ancv                             |  |                                      |   | 004 0-4-44   |  |
| death<br>a atter  | cian/Me       | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No       | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of o                | death 3                          | ☐ Ectopic pregnand ☐ Other (specify) _   | СУ                                   |   | 23d. Date of de<br>Month                                       | Day Year   |
| at the de by the tached   | Physi         | 9 Unknown  | 9 Unknown   |                                  |  |                                      |   |  |  |
| es tha  | by P          | Part II. Other significant conditions  | contributing to death but not res                                   | ulting in the u                  | nderlying cause giv                      | en in Part I.                        | 23e. Did to                               | obacco use contribute to                                       | the cause of death?                                |
| w requir  | ted           |  |   |                                  |  |                                      | _ 1 🗆 ١                                   | ′es 2 <u>∎</u> -Mo 3 □ P                                       | obably 4 Unknown                                   |
| e 2 sh  | Completed     |  |   |                                  |  |                                      | 24a. Was autop                            | sy prior to  | topsy findings available completion of cause of    |
| ician: The<br>certificate hi  | S             |  |   |                                  |  |                                      |   | rmed? death?<br>2 ☐ No 1 ☐ Yes                                 | 2 □ No   |
| vita<br>sician:<br>certific<br>rector,  | Be            | 25. Was case referred to medical examiner?                                   | Hospital:   |                                  | Ott                                      | ner:                                 | eath (Check only o                        |  |  |
| Phys  | <u>ان</u>     | 1 Yes 2 400  | 1 ☐ Inpatient 2 ☐   | ER/Outpaties<br>28b. Time o      | II 3 LI DOA                              | 4 LaGerdrsin                         |   | lence 6 Other (Spe   | cify)  |
| nding I   | tior          | 1 Natural 5 Pending<br>2 Accident investigation                              | (Month, Day, Year)  | Injury                           | Wor                                      | k?<br>]Yes 2 □ No                    | Zod. Describe i                           | iow injury occurred  |  |
| Atter<br>Pr dea<br>ector<br>by th   | ijiji         | 3 Suicide 6 Could not<br>4 Homicide determine                                |   | ome, farm, str                   | eet, factory, office                     |                                      |   | Street and Number or R.  | ural Route Number,                                 |
| itai or<br>rs afte<br>al Dir<br>led in  | Certification |  |   |                                  |  |                                      | City or Tou                               |  |  |
| To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director; A<br>completely filled in by the ft  | edical        | (Check only 2 Medical Exa  | Physician: To the best of my kno<br>aminer: On the basis of examina | owledge, deat<br>ation and/or in | h occurred at the ti                     | ime, date and pl<br>opinion, death o | ace, and due to the ccurred at the time.  | cause(s) and manner a<br>date and place, and due               | s stated.<br>to the cause(s)                       |
| Fo the I  | Med           | 29b. Signature and title of comier   | and manner stated.  |                                  | 29c. Licens                              |                                      |   | 29d. Date signed (Mont   |  |
| F≯Fö  |               | 15.1   | la 1  | ,                                |  | 0983                                 | 4   | 4/7/10   | ,,   |
| _   |               | 30. Name and address of person who   | o completed cause of death (Iter                                    | n 23a) (Tvpe                     |  |                                      |   | <u>-</u>   |  |
| _ 3   |               | 30. Name and address of person who BARRY N. ROSE                             | NBAUM 37Z   | O FA.                            | RRAGUT                                   | AVE. X                               | KENSINGT                                  | on, mo   | 20895  |
| 0.  | tate          | 31. Date filed (Month, Day, Year)  | 32. Registrar's Sign  | ture /                           |  |                                      |   | /  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** LO: HOPM Henry Junior Dangerfield 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BHLTIMORE AGNES HEALTheare 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Min. 213-36-9063 . Virginia Director May 25, 1937 West Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maritical Event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 724 Nottingham Road Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 □Yes 2 No Specify. \$ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Dangerfield ဂ Lucy Mae Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Dangerfield/Wife 724 Nottingham Road, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State April 23. 1 🕅 Burial 2 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Elkton, MD 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Mamon 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LO 00 W 1006 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initioalate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) law requires that the death certificate be exec Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 1 □Yes 2 □No o 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy The performe Vital 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 □ No funeral director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

26

32. Regist ar

|                            |  |                                | 1 - For<br>State<br>Registrar  | State of Ma  | ryland / Dep<br><i>Ce</i>             | artment<br>rtificate               |                                   |                                   |                                       | iene                        | 10                                 | 12873   |  |  |
|----------------------------|--|--------------------------------|--|--|---------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|---------------------------------------|-----------------------------|------------------------------------|---|--|--|
|                            |  |                                | 1. Decedent's Name (First, Middle, Las   | t)   |                                       |                                    |                                   |                                   | 2. Date of Deat<br>Month              | h<br>Day                    | Year                               | 3. Time of Death                                    |  |  |
| 1                          | Physici<br>/Medio  |                                | WALLACE  | M. EM  | BREY                                  |                                    |                                   |                                   | APRIL                                 |                             | 010                                | 9:45 A M  |  |  |
| 1                          | Examir   |                                | 4a. Facility Name (If not institution, give  |  |                                       |                                    |                                   | ition of Death                    |                                       |                             | nty of Death                       |   |  |  |
|                            |  |                                | 4420 LYNN BURKE R  | ·  | Marine to a binde de la               | -                                  | NROVI/                            | nder 24 Hrs.                      | C Date of Dist                        |                             | DERIC                              |   |  |  |
|                            | Funeral Director   |                                | 5. Social Security Number 6. Security Number 11  | M 2□F  | (In yrs. last birthday) 90 Yrs.       |                                    |                                   | ours Min.                         | 8. Date of Birth (Month, Day, Aug. 4  | Year)                       | Cou                                | nplace (State or Foreign<br>untry)<br>.rginia       |  |  |
|                            |  |                                | Usual Residence of Decedent  |  |                                       |                                    |                                   |                                   | Aug. 4                                | 1717                        | V 1                                | - SINIA   |  |  |
|                            | rylan<br>how   |                                | 10a. State 10b. County   |  | 10c. City, Town or L                  | ocation                            |                                   |                                   |                                       |                             |                                    | 10d. Inside City Limits                             |  |  |
|                            | Ba-f s   | ctol                           | Md. Frede  | rick   | Monrovi                               | a                                  |                                   |                                   |                                       |                             |                                    | 1 ☐ Yes 2 🛣 No                                      |  |  |
|                            | with th  | Funeral Director               | 10e. Street and Number 4420 Lynn Burke R   | oad  |                                       | 10f. Zip C                         |                                   | L770                              | 1                                     | 0g. Citizen o               |                                    | untry?<br>tates                                     |  |  |
|                            | s 23   | era                            | 11. Mantal Status  | 12. Was Decedent E   | ver in IIS 13                         | Was Deceder                        |                                   |                                   | ecify Yes or No-                      |                             |                                    | ican Indian,  |  |  |
| 36                         | within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Examitat reast be indiffind at   | by Fun                         | 1 Never Married 2 Married 3 Nover Married 4 Divorced   | Armed Forces?  1 Yes 2 1 N If Yes, Give Year or Dates:             | 0                                     | If Yes, specify                    | Cuban, Me                         | ecity:                            | Rican, etc.)                          | Spe                         | lack, White                        | hite  |  |  |
| 21215-0036                 | 2 hou  | ed                             | 15. Decedent's Ed  | ucation  | 16a. Dece                             | dent's Usual                       | Occupation                        |                                   |                                       | 16b. Kind of                | Business/I                         | ndustry   |  |  |
| 215                        | hin 72   | Completed                      | (Specify only highest grad   | de completed) College (1-4or 5-                                    | (Give                                 | kind of work<br>DO NOT use         | done during<br>retired)           | most of worki                     | ng                                    |                             |                                    |   |  |  |
|                            | d wit  | Com                            | Elementary/Secondary (0-12)  | 0  | L.                                    | ab Tecl                            | hnicia                            | an                                |                                       | U.S.                        | Gover                              | nment   |  |  |
| Maryiand                   | ould be filed with<br>Mental Hygiene.<br>Brkad other than<br>atic event, the   | To Be (                        | 17. Father's Name (First, Middle, Last) Rosier Embrey  |  |                                       |                                    |                                   | Maggie                            | (First, Middle, I<br>Gray             | Maiden Sum                  | ame)                               |   |  |  |
|                            | s 1 and 2 should be filed within 72 hours after death with the Marylan if Haith and Mantal Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examitur reast by notilitied at  |                                | 19a. Informant's Name/Relationship (7<br>Wanda L. Embrey /   |  |                                       | Monrovi                            |                                   |                                   | Zip Code)<br>L 770<br>Town, State     |                             |                                    |   |  |  |
| ore                        | of He of Herr  |                                | 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □  | Pamoval from State   | 20b. Place of Disponentery, cre       | osition (Name<br>matory or other   | of<br>er place)                   | С                                 | Date                                  | 20c. Locatio                | n - City or 1                      | Town, State   |  |  |
| Ĕ                          | Pages<br>ment of<br>ent: If it<br>ury or o   |                                | `4 □Donation 5 □ Other (Specify  |  | Pleasan                               | t Hill                             | Cem.                              | 4/14                              | /10                                   | Monro                       | via,                               | Maryland  |  |  |
| Baltimore,                 | permit. Pages<br>Department of<br>Importent: If it<br>any injury or once.  |                                | 21. Signature of Peneral Service Licensee  22. Name and Address of Facility Muriel H. Barber Funeral Home P. 0. Box 5038, Laytonsville, Md. 20882  |  |                                       |                                    |                                   |                                   |                                       |                             |                                    |   |  |  |
|                            | Physician and physician and physician and physician and physician and physician and physician are the physician and physician and physician are the physician and physician are the physician and physician are the physician and physician are the ph | Examiner                       | 23a. Fart1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a c.  | consequence of):                      | ò                                  |                                   | A                                 | L Jhiy                                |                             |                                    | Approximate Interval Between Onset and Death 5 days |  |  |
| P.O. Box 68760,            | the death certifi<br>by the attending f<br>ached for use as  | Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | d  | 2 ☐ Fetal death 3[                    | □Ectopic preg<br>□ Other (spec     |                                   |                                   |                                       |                             | Date of deli                       | very<br>Day Year                                    |  |  |
|                            | w requires that<br>s been signed b<br>should be deta   | d by P                         | Part II. Other significant conditions co   | prostate   | t not resulting in the t              | underlying cau                     | ise given in                      | Part I.                           |                                       | oacco use co<br>es 2 □ No   |                                    | the cause of death?                                 |  |  |
| Division of Vital Records, | ne law req<br>n has beer<br>ge 2 shou  | mplete                         | Renol tist   | Truny  |                                       |                                    |                                   |                                   | 24a. Was a autops                     | y                           | b. Were au<br>prior to d<br>death? | topsy findings available<br>completion of cause of  |  |  |
| a                          | n: Tr<br>ficate<br>rr, pa  | e<br>Co                        | 25. Was case referred to medical   | · · · · · · · · · · · · · · · · · · ·                              |                                       |                                    |                                   |                                   |                                       | 2 140                       |                                    | 2 No  |  |  |
| ₹                          | Physicien:<br>this certific<br>ral director,   | 8                              | examiner?  | Hospital: 1 ☐ Inpatier   | nt 2 ER/Outpatie                      | nt 3 DOA                           | Othor                             | □ Nursing Ho                      | (Check only on                        | ence 6 🗆 (                  | Other (See                         | 16.1  |  |  |
| of                         | g Phy<br>er this<br>eral d   | n: To                          | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day                                 | · · · · · · · · · · · · · · · · · · · |                                    | : Injury at<br>Work?              |                                   | 28d. Describe ho                      |                             |                                    | ny)   |  |  |
| jon                        | nding<br>ath.<br>r: Alte<br>e fun  | atlo                           | 2 ☐ Accident investigation   |  | Year) Injury                          | М                                  | Work?<br>1 ☐ Yes                  | 2 🗆 No                            |                                       |                             |                                    |   |  |  |
| Divis                      | al or Atte<br>after des<br>I Directo<br>d in by th   | Certification:                 | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | reet, factory,   | office                                |                                    | 28f. Location (Si<br>City or Town |                                   | mber or Ru                            | ral Route Number,           |                                    |   |  |  |
|                            | To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2   | Medical C                      | 29a. Certifier  (Check only one)  12 Certifying Ph 2 Medical Exam  | ysicien: To the best o<br>iner: On the basis of<br>and manner stat | examination and/or in                 | th occurred at<br>ovestigation, in | the time, da                      | ate and place,<br>n, death occurr | and due to the c<br>ed at the time, d | ause(s) and<br>ate and plac | manner as<br>e, and due            | stated.<br>to the cause(s)                          |  |  |
| )                          | To the within To the Comp  | X                              | 29b. Signature and title of certifier  | 11_  | mo                                    | 1                                  | License nun                       | onber<br>0 4                      | 2                                     | 9d. Date sig                | ned (Month                         | n, Day, Year)                                       |  |  |
|                            | ) <u>(*</u>  |                                | 30. Name and address of person who   |  |                                       | -                                  | #202                              | M+ 4 •                            | 361                                   | 017-                        | 7 1                                |   |  |  |
|                            | 15   |                                | Gail Griffin, M.D. 31. Date filed (Month, Day, Year)   |  | S. Main St                            | reet,                              | 11 ZUZ,                           | MU. Al                            | ry, Ma.                               | 2177                        | 1                                  |   |  |  |
|                            | Sta  | ite                            | ADD 1  | 2010   | - Signature                           | Sugar                              | 4                                 |                                   |                                       |                             |                                    |   |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April William Henry Edwards 2010 2:05a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Anne Arundel Severna Park Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 27, 1923 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Hours Country) 86 Director Yrs. 216-14-1487 Maryland Usual Residence of Deceden 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hyglene. The firem 27 is market of Lefter than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 North Old Mill Bottom Road 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Electrician U.S. Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ John Edwards Amelia Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau once. Dan Knott/Nephew 761 218th Street Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Bunal 2 K Cremation 3 Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, MD Name and Address of Facility arranco & Sons, 95 Gov. Ritchie Funeral Service Licensee 22. Name and Addr Rarranco 495 Gov. P.A. Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ obstru disease or condition resulting in death) chronic Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the a ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the eause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performe 1 Yes Yes 2 25. Was case referred to meetical Be 26. Place of Death (Meck only one) examiner? 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 - Pending death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

Completed filled in by the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, in my opinion, data and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) re and title of

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

DHMH 17 Rev 7/2009

0. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

860

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Ye ar **Physician** Rosezina Victoria Franco 10:39 ກັ April 5 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Health Care-The Pines Talbot Easton H Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Dec. 16, 1933 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1 □ M 21 F 76 214-32-7385 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widdle Evanthan must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Hurlock Director MD Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21643 7006 Butler Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 To least 1 Yes, Give Year or Dates: 1 Never Married 2K Married 2 **X**No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🗓 No Specify. Specify: <u>8</u> 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Johns John Friend ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7006 Butler Rd., Hurlock, MD 21643 Pedro Franco 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/21/10 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland Washington Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. Michael Federalsburg, MD 21632 216 N. Main St., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or 35 a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or a consequence of): sician and burial-trans physician Box 68760 Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) P.0. ned by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate **Division of Vital** 1 □ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signatu Day, Year) State 19 Registrar

DHMH 17 Rev 1/2001

Franco

Rosezina

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ April Audrey Caroline Gohl <sup>D</sup>2010 6 3:55 p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1555 Hrs Baltimore Gilchrist Center for Hospice Care Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗙 F OCT 12, Year) 918 New York Director 130-03-1380 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 Tyes 2 X No 2010 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 8100 Rossville Blvd USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian whey Gohl April6, Black White etc þ 1 Never Married 2 Married Yes 2 No Baltimore/Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jenkins Carrie Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Gohl, son 57 Crosswind Drive, Shrewsbury, PA 17361 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Greenfield Cemetery 4/12/2010 Hempstead, NY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home R 91 Willis Street, Westminster, MD 21157 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Femu disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: asn. 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown P.O. ed by t detach signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should the completed filled in by the funeral director, page 2 should the completed filled in by the funeral director. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examine. 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HGS PICO 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 2 Accident work? 5 Pending March 27,2010 unknown
28e. Place of Injury - At home, farm, street, building, etc. (Specify)
45515100 Living Investigation un known 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number Blud City or Town, State) \$ 100 Ross J. 40 Blud Rosdal & MD 21237 determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) WIL 10 of death (Item 23a) (Type, Print) 7 Luthonville, Md 21093 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.: Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GOMEZ 5:57 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin Hospice House 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) California **1V** M 2 □ F Months 0177671922 Director 566-20-3438 88 Usual Residence of Deceden ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14997 Health Center Drive 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. 1942-46 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Hispanic 3 Widowed 4 X Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Electrical Engineer 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Julian Gomez Mercedes Ramirez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dena Selby/Daughter P.O. Box 172, Cheltenham, Maryland 20623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory Baltimore, Maryland 04/06/2010 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that the death certificate be executed g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Pregnant at time of death Month Day Year 5 Other (specify) detached 1 ☐ Yes ∠ ☐ g ☐ Unknown a Unknown by i P.O. s been signed I should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy page performed 1 Yes 2 No 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner' Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 Ø Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending (Month, Day, Year) s after death. 2 🗌 No Accident Investigation 1 Yes completed filled in by the 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifie Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signatu nd title of certifie 30. Name and address of person who completed cause of ceath (Item

DHMH 17 Rev 7/2009

State Registrar

|                           |   |                   | 1 - State of Maryland / Department / Department / Departme | artment of Health and N<br>rtificate of Death   | lental Hygiene<br>Reg. No.              | 2610 12878   |
|---------------------------|---|-------------------|--|---|---|--|
|                           |   |                   | Decedent's Name (First, Middle, Last)  |   | 2. Date of Death                        | 3. Time of Death   |
|                           | Physicia  |                   | George C. Giddens, Sr.   |   | Month Day April 9,                      | 2010 10:44 P M   |
|                           | /Medic<br>Examin  |                   | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  |   | County of Death  |
|                           |   |                   | 3106 Lancer Place  | Hyattsville   | Pr                                      | ince George's  |
|                           | Funeral   |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ★ M 2 □ F  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                                | 8. Date of Birth<br>(Month, Day, Year)  | Birthplace (State or Foreign Country)                                |
|                           | Director  |                   | 214-01-7660 Residence of Decedent  |   | 12-05-1920                              | Washington, DC   |
| 1                         | and and   |                   | 10a. State 10b. County 10c. City, Town or Lo   | cation  |   | 10d. Inside City Limits  |
| 1                         | f sh  | ţ                 | MD Prince George's Hyattsvil   | 1.  |   | 1 <b>X</b> Yes 2 ☐ No  |
| 4                         | 289   | Director          | 10e. Street and Number   | 10f. Zip Code   | 10g. Citi                               | izen of What Country?  |
| dim                       | 3a ol   |                   | 3106 Lancer Place  | 20782   | Uni                                     | ted States   |
| 1                         | ms 2  | Funeral           | 11 Marital Status 12. Was Decedent Ever in U.S. 13.1   | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto          |   | 14. Race - American Indian,  |
| စ္ ေ                      | or ite  |                   | 1 ☐ Never Married 2 ☐ Married   1 📉 Yes 2 ☐ No   | 1 □Yes 21 No Specify:   | riicari, etc.)                          | Black, White, etc.  Specify: White                                   |
| 5-0036                    | The free with the many and the free the many and the free white the many and other than "natural", or items 23a or 28a-f show event, I're Medical Examinar must be motified.                          | d by              | 3 K Widowed 4 □ Divorced Year or Dates:  |   |   |  |
| 2                         | "nati   | Completed         | (Specify only highest grade completed) (Give   | dent's Usual Occupation<br>kind of work done during most of work<br>DO NOT use retired) |   | ind of Business/Industry   |
| 7                         | Hygiene.  Hygiene.  Sther than "nai ent, the Medici   | m<br>di           | Elementary/Secondary (0-12) Coilege (1-4or 5+) Superv  | ,   | MCC                                     | C- Private   |
| ק<br>ס                    | al Hygie<br>other I   | ပိ                | 17. Father's Name (First, Middle, Last)  |   | e (First, Middle, Maiden                |  |
| yland                     | and Mental I is marked of raumatic eve  | To Be             | George W. Giddens  | Naomi G   | roome                                   |  |
| ב ל                       | and M   | -                 |  | ng Address (Street and Number or Rui  | ral Route Number, City o                | or Town, State, Zip Code)  |
| Mar                       | alth a  |                   | George C. Giddens, Jr ( Son )   4700   | Gallatin St. Ed   | monston, MD                             | 20781  |
| aitimore,                 | penimit. rages 1 ain 2 should be perimit. rages 1 ain 2 should be periment of Health and Merim Important: If item 27 is an arked any injury or other traumatic events.                                |                   | 20a. Method of Disposition 20b. Place of Disposition cemetery, crer  | sition (Name of matory or other place)  | Date 20c. Lo                            | ocation - City or Town, State  |
| Ĕ                         | ant: If   |                   | 1 TBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Line  | oln Cemetery 4/12   | /2010 Bren                              | twood. MD  |
| <u>a</u>                  | Departi<br>Departi<br>Importa<br>any inj  |                   |  | 2. Name and Address of Facility $For$   |   |  |
| מ                         | 20 E 20 9   |                   | School Chony -1 34   | 01 Bladensburg Ro   | ad Brentwo                              | od, MD 20722   |
|                           |   |                   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  | er the mode of dying, such as cardiac   | or respiratory arrest,                  | Approximate<br>Interval Between<br>Onset and Death                   |
|                           | hysician  |                   | Immediate Cause (Final disease or condition  Metastatic Bladde   | r Cancer  |   | moulls   |
|                           | /Medical<br>xaminer   |                   | resulting in death)  Due to (or as a consequence of):  |   |   |  |
|                           | .xummer   | ē                 | Sequentially list conditions, if any, landing to immediate   | isease  |   |  |
| 70                        | isit s  | nin               | Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury that initiated events   |   |   |  |
| , a                       | al-trai   | Examin            | that initiated events c  |   |   |  |
| 875U,                     | physician and<br>the burial-transit   | dical E           |  |   |   |  |
| 20 2                      | ng phy<br>as th   | ledi              |  |   |   |  |
| XON S                     | lendir<br>r use   | Physician/Me      | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □   | ☐ Ectopic pregnancy   |   | 23d. Date of delivery  |
| ָרָ הַּ                   | he etf  | sicie             | 1 Yes 2 No 4 Pregnant at time of death 5   | Other (specify)   |   | Month Day Year   |
| ר<br>ס                    | d by the  | بالخ              | 9 Li Unknown   |   |   | and death?   |
| Š,                        | signed<br>be d  | þ                 | Part II. Other significant conditions contributing to death but not resulting in the u   | nderlying cause given in Part I.  |   | use contribute to the cause of death?                                |
|                           | een s   | ted               |  |   | 1 ☐ Yes 2                               | □ No 3 □ Probably 4 💢 Unknown  |
| Mecords                   | has b   | Completed         |  |   | 24a. Was an autopsy                     | 24b. Were autopsy findings available prior to completion of cause of |
| <u></u>                   | icate<br>; pag  | දු                |  |   | performed?<br>1 □ Yes 2√√ No            | death?<br>1 □ Yes 2 □ No   |
| Vitai                     | certif  | Be                | 25. Was case referred to medical examiner?   | Othor   | th (Check only one)                     |  |
| o å                       | al di   | £.                | 1 ☐ Yes 2 ☐ No   | 1 3 DOA 4 Nursing H   | ome 5 Residence 28d. Describe how injur |  |
| ם פֿ                      | Afte<br>fune  | ţ                 | 1♥ Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation  | Work?<br>M 1 □ Yes 2 □ No   | 200. Describe now injur                 | y occurred   |
| DIVISION<br>Lor Attending | deat<br>ctor:<br>y the  | fica              | 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, str   |   | 28f. Location (Street ar                | nd Number or Rural Route Number,                                     |
| 5                         | d in b  | Certification: To | 4 ☐ Homicide determined building, etc. '(Specify)  |   | City or Town, State                     | 9)   |
| chira                     | within 24 footure after death.  To the Funeral Director: After this certificate has been signed by the ettending I completely filled in by the funeral director, page 2 should be detached for use as |                   | 29a. Certifier XX Certifying Physician: To the best of my knowledge, deat  | h occurred at the time, date and place  | , and due to the cause(s                | s) and manner as stated.   |
| Å<br>K                    | in 24<br>he Fi  | Medical           | (Check only one) 2 Medical Examiner: On the basis of examination end/or in and manner stated.  | ivestigation, in my opinion, death occu   |   |  |
| Ę                         | vith com  | Σ                 | 29b. Signature end title of certifier  | 29c. License number   |   | ite signed (Month, Day, Year)  |
|                           |   | ļ                 | Swon Green   | D 14876   | 4/                                      | 12/2010  |
| 01                        | 10+,  | ĺ                 | 30. Name and address of person who completed cause of death (Item 23a) (Type,  |   |   |  |
| <u></u>                   | /   |                   | Suresh Gupta, MD 3503 Perry Street  31. Date filed (Month, Day, Year) 32. Registrar's Sanature.  | Mt. Rainier, MD 2   | 0712                                    |  |
|                           | Sta   | te<br>ar          | 31. Date filed (Month, Day, Year)  APR 1 3 2010  April 32. Registrar's Senature  |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** 9 2010 P M Miriam Althea Harper April 8:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mallard Bay Care Center Cambridge Dorchester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🖺 F 89 24, 177-14-5869 1921 Maryland Director Jan. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County is than "natural", or items 23a or 28a-f show the Medical Examinant he molified at 1 X Yes 2 No Director Maryland | Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 USA 520 Glenburn Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🗓 No Specify Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fili ment of Health and Mental H iant: If Item 27 is marked off lury or other traumatic even Be Mary Ella Constable Hubert Cropper Harper ഉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2404 Fairway Drive, Richardson, Texas 75080 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tx. Meredith W. Driscoll/Cousin Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Unity Washington Cem 4/12/2010 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 20
106 Main Street, East New Market, 21. Signature of Frineral Service Licensee Box 207 MD 21631 Approximate Interval Between Onset and Death Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one enuse on each line. Immediate Cause (Final Physician Sepsis week disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Urinary fract Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part L Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2½ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 o σ. Division of Vital Records,

death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed physician and s the burial-trans attending p signed by the a should cate has by page 2 s certificate or Attending Physician: director, this After thi funeral of death. reral Director: / after within 24 hours a

To the Funeral I To the Hospital

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Ron

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Bramble

and manner stated.

Registrar's Signaty

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Day, Year)

|   |       | -                 | _ State  | State of Ma   | aryland        | -                             | rtment of I<br>tificate of                                 |                                 | nd Menta                         |                              | 2111                                  | 0                  | 12880  |     |
|---|-------|-------------------|--|---|----------------|-------------------------------|--|---------------------------------|----------------------------------|------------------------------|---------------------------------------|--------------------|--|-----|
|   |       |                   | 1. Decedent's Name (First, Middle, Last)   |   |                |                               | inoute or  | Douth                           |                                  | te of Death                  | Day Ye                                | ar                 | 3. Time of Death                                   |     |
| Physi<br>/Med   |       |                   | Donald Wheeler   | Haring  |                |                               |  |                                 | Apr                              |                              | 9 2010 10:                            |                    |  | 1   |
| Exam  | nine  |                   | 4a. Facility Name (If not institution, give str<br>3742 Rumsey Driv  |   |                |                               | 4b. City, Town, o  |                                 | Death                            |                              | 4c. County of Death Talbot            |                    |  |     |
| Funera  |       |                   | 5. Social Security Number 6. Sex 11/2 N  | 7. Age  | e (In yrs. las | st birthday)<br>Yrs.          | If Under 1 Year<br>Months Days                             |                                 | Min. (M                          | te of Birth<br>onth, Day,    | Year) 9.                              | Birthpla<br>Counti | ace (State or Foreign)<br>Land                     | n   |
| Directo   |       |                   | Usual Residence of Decedent  |   |                |                               | 1  |                                 | Jai                              | 1. 14,                       | 1937  1                               |                    |  |     |
| Marylar<br>f show   |       | 5                 | MD 10b. County Talbot  |   | 10c. City,     | Town or Loc                   | ation  | Trapp                           | е                                |                              |                                       | 10                 | d. Inside City Limits<br>1 ∰Yes 2 ☐ No             |     |
| or 28a  |       | rullelal Dilector | 10e. Street and Number   |   |                |                               | 10f. Zip Code  | 21673                           |                                  | 109                          | g. Citizen of Wha                     | t Count            | ry?  |     |
| ns 23a  | 3     | <u>a</u>          | 3742 Rumsey Drive  | . Was Decedent I  | Ever in U.S.   | 13. V                         | las Decedent of P<br>Yes, specify Cub                      |                                 | in? (Specify Ye                  | es or No-                    | 14. Race -                            | America            |  | _   |
| ours after ours!, or iter   | 1     | 2                 | 1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced   | Armed Forces? 1 □Yes 2 □ N If Yes, Give Year or Dates:    | No             |                               | Yes, specify Cub<br>☐Yes 2√ No                             | an, Mexican, Specify:           | Puerto Rican,                    | etc.)                        | Black, V<br>Specify:                  |                    | ite  |     |
| 72 ho   |       | Confibered        | 15. Decedent's Educa<br>(Specify only highest grade of   | tion<br>completed)  |                | (Give F                       | ent's Usual Occup<br>aind of work done<br>O NOT use retire | during most of                  | of working                       | 16                           | 6b. Kind of Busin                     | ess/Ind            | ustry  |     |
| d within giene.   |       | 5                 | Elementary/Secondary (0-12)  | College (1-4or 5  | +)             | ##C. D                        | owner  |                                 |                                  |                              | clothi                                | ng :               | store  |     |
| d be file<br>ental Hy<br>ced oth<br>c event   | 6     | บ                 | 17. Father's Name (First, Middle, Last)  A. Stuart Harin   | g   |                |                               |  | Į.                              | 's Name <i>(First</i><br>is Whee |                              | aiden Surname)                        |                    |  |     |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertalla Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be notified at | F     | =                 | 19a. Informant's Name/Relationship (Type<br>Patricia Haring  |   |                |                               | g Address <i>(Street</i><br>Rumsey D                       |                                 |                                  |                              | City or Town, Sta                     | nte, Zip           | Code)  |     |
| es 1 an of Hea  |       | Ī                 | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei  | moval from State  |                |                               | sition (Name of<br>atory or other pla                      | ce)                             | Date                             | - 1                          | 0c. Location - Cit                    |                    |  |     |
| Definition  Permit. Pages Department of mportant: If it   | ai.   | -                 | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  |   | Dorc           |                               | Name and Addre   |                                 | 4/17/10                          |                              | Cambrid<br>neral Ho                   |                    |  |     |
| Depart any i  | ouce. |                   | the low  | _   |                |                               | 00 Locus   |                                 |                                  |                              |                                       |                    | .A.  |     |
|   |       |                   | 23a. Part . Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final   | cause on each lir   | ne.            |                               |  | ing, such as c                  | cardiac or resp                  | iratory arres                | st,                                   |                    | Approximate<br>Interval Between<br>Onset and Death |     |
| Physicia<br>/Medica   | al    |                   | disease or condition resulting in death)   | Due to (or as   |                |                               | CERC   |                                 |                                  |                              |                                       | -                  | n byr  | 2   |
| Examine   |       | _ G               | Sequentially list conditions, if any, leading to immediate   | Due to (or as   | a conseque     | ence of):                     |  |                                 |                                  |                              |                                       |                    |  |     |
| acuted<br>nd<br>transit   |       | Examilier         | that initiated events c.   |   | ,              |                               |  |                                 |                                  |                              |                                       |                    |  |     |
| icate be executed physician and the burial-transit  | 1     | acical Ex         | resulting in death) Last   | Due to (or as   | a conseque     | ence of):                     |  |                                 |                                  |                              |                                       |                    |  |     |
| ertificat<br>ling phy<br>e as the   |       |                   | IF FEMALE:   |   |                |                               |  |                                 |                                  |                              |                                       |                    |  | - 1 |
| on or Vital Records, F.O. Box of ding Physician: The law requires that the death certified.  After this certificate has been signed by the attending funeral director, page 2 should be detached for use as   |       | Physician/in      | 23b. Was decedent pregnant in the past 12 months?  | c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a    | 2 Fetal o      | death 3                       | Ectopic pregnan<br>Other (specify) _                       | су                              |                                  |                              | 23d. Date of Month                    |                    | ry<br>Day Year                                     |     |
| at the d by the etache  | 2     | Fnys              | 9 Unknown  Part II. Other significant conditions contr   | 9 Unknown   | ut not recult  | ting in the un                | idarlyina eausa di   | von in Part I                   | 2                                | 3e Did tobs                  | acco use contribu                     | ite to th          | e cause of death?                                  |     |
| ecords, law requires th as been signe 2 should be d   |       | og pg             | Tartii. Other significant conductors cond  |   | at not result  | ang ar trie tr                |  | ven mi i di ci.                 | _    -                           | 1 ☐ Yes                      | \ /                                   |                    | ably 4 Unknow                                      | 'n  |
| law rehas bee   |       | Completed         |  |   |                |                               |  |                                 | 2                                | 4a. Was an<br>autopsy        | pric                                  | r to con           | esy findings availab<br>opletion of cause of       | e   |
| VICAL FIGURE The Iclan: The certificate ector, page   |       |                   | 25. Was case referred to medical   |   |                |                               |  | 26 Place                        | of Death (Che                    | perform  Yes 2               | <b>X</b> No 1□                        | th?<br>Yes         | 2 □No  |     |
| OT VI Physician this cer  | 1     | 10 De             | examiner?<br>1 ☐ Yes 2 No  | spital:<br>1 ☐ Inpatio                                    |                | R/Outpatien                   | 1 3 DOA  | her: 4 🗀 Nur                    |                                  | _                            | nce 6 Other                           | (Specify           | )  |     |
| Attending Part death. ector: After 1 by the funera  |       | IIOU:             | 27. Manner of Death  1.  | 28a. Date of Inju<br>(Month, Da                           |                | 28b. Time of<br>Injury        | 28c. Inju<br>Wo<br>M 1                                     | ıryat<br>rk?<br>]Yes 2 ∐ N      |                                  | escribe hov                  | w injury occurred                     |                    |  |     |
| LIVISION I or Attending after death. Director: After d in by the fune   |       | Certification:    | 2   Accident   Acciden |   |                |                               |  |                                 |                                  |                              |                                       | or Rura            | Route Number,                                      |     |
| DIVISIO  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A  completely filled in by the f.  |       | Medical           | 29a. Certifier (Check only one) 12 Certifying Physical Certifier 2 Medical Examina   | cian: To the best<br>er: On the basis of<br>and manner st | of examination | rledge, death<br>on and/or in | occurred at the vestigation, in my                         | time, date and<br>opinion, deat | d place, and d<br>th occurred at | ue to the ca<br>the time, da | ause(s) and manr<br>te and place, and | ner as st          | ated.<br>the cause(s)                              |     |
| To th<br>within<br>To th  | 2     | ME                | 29b. Signature and title of certifier  | SM/   | , ,            |                               |  | se number                       | 1                                | 29                           | Od. Date signed (                     | Month, E           | Day, Year)   |     |
|   |       |                   | 30. Name and address of person who com<br>David H. Smith, M.I  | pleted cause of c   | leath (Item )  | 23a) (Type,<br>Dr             |  |                                 |                                  | MD 21                        | 1601                                  |                    |  |     |
|   | State | 9                 | 31. Date filed (Month, Day, Year)  |   | rar's Signatu  |                               | Salle S  | UZ, LIC                         |                                  |                              |                                       |                    |  |     |
| Regi  |       |                   | APR 14 20  | TU Alexander  | and I          | H. A                          | 100/00   |                                 |                                  |                              |                                       |                    |  |     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year Physician/ 11:40a M April Richard P. Henderson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Vindabona Nursing Home Braddock Heights Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) **Funeral** (Month, Day, 1 🛛 M 2 🗆 F Months Days Country) Maryland Director 90 1919 Oct. 213-18-8873 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 United States 5309 Ivywood Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Year or Dates. WW II Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. larked other than Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the U.S. Government Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daniel Benjamin Blaine Henderson Mary Nancy Virginia Graham .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5309 Ivywood Drive, Frederick, Maryland 21703 Clarice Foreman/ Step-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Burkittsville, Maryland 4 Donation 5 Other (Specify) Bethel AME Cemetery 4/10/2010 21. Signature of uneral Ser 22. Name and Address of Facility. Stauffer Funeral Homes 1621 Opossumtown Pike, P. A. Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complication Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ ons estrue disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Securations list numbers if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive Dulmonar 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

(Check only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Kathleen Stern M.D. 610 9th Avenue,

Brunswick, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

032013

29d. Date signed (Month, Day, Year)

21716

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April George A. Jenkins, Jr. 2010 12:39p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death Ceci1 E1kton Union Hospital 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 XM 2 □ F Months Days Hours Min. Jan 27, 1946 219-44-5487 Director 64 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Ceci1 1 Yes 2 XNo Rising Sun 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2416 Red Toad Rd. 21911 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Union Local 626 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည George A. Jenkins Sr. Rose Mary Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is 2416 Red Toad Rd. Rising Sun, MD 21911 Brenda Jenkins/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 6 4/12/2010 me, P.A. injury o Foard Funeral Home, 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD Signifure of Funeral Service License Name and Address of Facility
T. Foard Funeral Home,
I S. Queen St. Rising any SUn, 23a. Part It. Enter the disease, or complications that causeshook, or heart failure. List only one course on each ine. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical ゴダゲー Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy perform After this certificate 1 🗌 Yes 2 🕱 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 1 Yes 2 🗌 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Floute Number, City or Town, State)

24 | Record Rd RISUND filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопретен (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗔 within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit

10+1VA

LL

State Registrar 30. Name and address of p

31. Date filed (Month, Day, Year, 32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Emily Blair Jorss April 10 2010 1:53 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖫 F Pennsylvania Dec 21, Director 65 1944 215-42-1597 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at Yes 2 No Director Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 510 Pinehurst Cir Apt. T4 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 20 Married Maryland 21215-0036 1 ∐Yes 2√∑No Specify <u>≨</u> Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Frederick County Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be t Health and Mental 127 is marked er traumatic e 2 Edward E. Bitner Mary Blair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Pinehurst Cir. T4 Westminster, MD C. Roger Jorss, Jr. Husband If item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Druid Ridge Cemetery 4/16/2010 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 27/No 3 Probably 4 Unknown Completed 1 Tyes , page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐Yes 2 ☐No 2 Accident investigation within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 24 hours a 29a. Certifier ca 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o one) 29b. Signati 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number address of person w o completed cause of death (Item 23a) (Type, Print) NESTHIUSES, MD 21137 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** William A. Jeffries 2010 3:55 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Retirement Center Williamsport Washington Birthplace (State or Foreign Country) If Under 1 Year | If Under 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F Director 233-34-5919 88 23,1922 Thomas, WV Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be mothed at 1 XYes 2 □ No Director MD Williamsport Washington 10g. Citizen of What Country? 10e. Street and Number 16505 Virginia Avenue 21795 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Mydical Exercition 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 ☑ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent Paper Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel B. Jeffries ဥ Isabelle W. McLuckie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Dawn Jeffries/Wife 16505 Virginia Avenue Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 19 The 2010 Cumberland, MD Cumberland Crematory 21. Signature of Euneral Service 22. Name and Address of Facili Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of duing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a h line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is death). Leaf Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) s been signed by the should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐Yes 2 ☐ No 1 □ Yes 2 Fo the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation dea h. ours fter death.

leral Director A
filled in by the fu 1 ☐ Yes 2 🔲 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 D Homicide within 24 hours
To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar ) DHMH 17 Rev 1/2001

DIC

29b. Signature

Regist

29d. Date signed (Mghth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yun Ok Kim 0430 2010 April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day May 27 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 226-25-4186 1 □ M 2 🗓 F 92 Yrs. Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Funeral Director Silver Spring MD Montgomery 1 Yes 2 X No 10f. Zip Code 20902 10e. Street and Number 10g, Citizen of What Country? 4011 Randolph Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", Specify: Asian Completed 3 XWidowed 4 Divorced of Health and Mental Hygiene. item 27 Is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental : Important: If item 27 is marked of any injury or other traumatic eve မ Byung Kim Soon Lee Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall Park/Grandson 4923 Novak Lane, Fairfax, Virginia 22030 20a. Method of Disposition 20b. Place of Disposition (Name of Fafriax Memorial Funeral Home 1 Burial 2 X Cremation 3 Removal from State Fairfax, VA 2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA2203 K. En 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Respiratory Failure Medical resulting in death) Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Advanced Dementia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 12 No this certificate 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗙 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my investigation occurred at the time, date and place, and due to the cause(s) and manner as attack. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar D66372

Majid, 1500 Forest Glen Rd., Silver Spring, MD 20910

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Pahmanian

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rahmanian -Shahri

31. Date filed (Month, Day, Year

APR 1 3 2010

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Physician Arnold 2010 /Medical pn 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 **X** M 2 □ F Days 65 348-36-2190 Feb. 27, 1945 **Director** Illinois Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 🔀 No VA Fairfax McLean Director Examiner must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 1008 Heather Hill Ct. 22101 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify. Š Specify: Caucasian 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) than al Hygiene. The Scowcroft Group 5+ Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Norton W. Kanter Mary Stern Kanter ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 is or other tra Anne Strassman Kanter-Wife 1008 Heather Hill Ct., McLean, VA 22101 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State airfax Memorial Funeral Home 1 Burial 2 XCremation 3 Removal from State April permit. Page Department of Important: If any injury or once. Fairfax, VA 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA 22032 · Fanns Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Leukemia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 🗌 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural Injury 2 Accident 1 Yes 2 No the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. or Attending Physician: s after death.

Director: Aft filled in by

24 hours a Hospital completely

To the within 2 To the F 30

4 Homicide

(check only

and title of certifie

29a. Certifier

Medical

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SREELYN AWIL M 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 2. Registrar's Signature 12

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Em Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** APR 16 2010 ONIS MARLYN KENNEMER 7:52 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2**X** F Months Days 05/29/1930 Director Mississippi 412-40-0534 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Everniner must be nutified at 1 ☐ Yes 2 🙀 No Director VA Fairfax Great Falls 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 9701 Mill Run Drive 22066 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home it of Health and Mental Hyg If item 27 Is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be need on the Pages 1 and 2 should be 1 Ernest F. Sparks Ella Adams 2 19a. Informant's Name/Relationship (Type. Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701 Mill Run Drive Great Falls, VA Christopher E. Kennemer, Sr. 22066 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page
Department of
Important: If
any Injury or
once. Arnon Cemetery 04/23/2010 Great Falls. VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licensee 22. Name and Address of Facility 721 Elden St. Herndon, VA 20170 Adams-Green Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Josasson apary that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 ☑No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation ; after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or within 24 hours a
To the Funeral L ical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 04/16/10 Rachel Greenberg D0069249 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER RACHEL S. GREENBERG
31. Date filed (Month, Day, Year)

APR 2 6 20 BETHESDA MD 20889-5600 32. Registrar's Signature State 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leit 2 AM 10 10 ADI 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Hours Min MAR 6, 1932 457-50-0457 78 Director Texas I sual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Howard Savage 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 8411-A Foundry Street 20763 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 Married Maryland 21215-0036 1 M Yes 2 □ No Specify: Mexico / Spain If Yes, Give Year or Dates Specify: Caucasian Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Own Home / Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker / Beutician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Tamez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Leitz / Daughter 8411A Foundry Street, Savage, MD 20763 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or San Marcos City Cem. 04/17/2010 San Marcos, TX 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thomason Funeral Home M01508 2001 Ranch Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) ascending Medical Due to (or as a consequence f): Examine Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an autonsy disseminated coaquelation After this certificate 1 ☐ Yes 2 ☐ 416 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Tinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 2010 10066515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 5755 Cedar Lane, Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature MARAN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend#5, per FH, QACHD, 4/15/10, ms Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3010  $\mathbf{P}_{\mathsf{M}}$ 2:00 EUGENE OLIVER LEGG, JR. Apri Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death at Mospital Costor If Under 1 If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Hours Min SEPT. 28,1930 MARYLAND 79 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a, State 10b. County with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No QUEEN ANNE'S CENTREVILLE MARYLAND 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1309 HOPE ROAD 21617 UNITED STATES death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) WATERMAN permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other traumatic event, the once. SEAFOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EUGENE OLIVER LEGG, SR. NATALINE HUNTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE THOMAS/DAUGHTER 316 MELVIN AVE., QUEENSTOWN, MD 21658 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of CHESAPEAKE) CREMATION 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State APRIL STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 2010 21. Signature of Funeral Service Licenses TELLOWS drehelfenbein & Newnam Funeral Home, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ physema disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed 1 ato physician and the burial-trans that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ed by the attending properties of detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 🗆 No 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: performe Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Tyes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending in 24 hours and the Funeral Director; Af 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Description in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie icense number

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (

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Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>10</u> Physician April 11, George 11oyd, Jr. 10:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10821 Keysville Road Emmitsburg Frederick 8. Date of Birth Oct 13, 1941 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Hours Min. Massachusetts 1 X M 2 □ F 021-30-7982 68 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examiner must be readiled anonge. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2 No Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10821 Keysville Road 21727 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White If Yes, Give Year or Dates: Specify: Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George H. Lloyd, Winifred Α. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Lloyd/Wife 10821 Keysville Road, Emmitsburg, Md 21727 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory PR 13,2010 Frederick MD 22. Name and Address of Facility Stauffer Funeral Home, Pa 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service 104 E. Main Street, Thurmont, Md 21788 Enlegge disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Disk to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No the detached as been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 <del>Ve</del>s 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated.

Registrar

State

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29b. Signature and the of certifier

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31. Date filed (Month, Day, Year)

fed cause of death (Item 23a) (Type, Print)

300 W

32. Registrar's Signature

MD

29d. Date signed (Month, Day, Year)

6428

FREDERICK, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edward D. Physician/ Lucas April 3, Day 2010 Year 7:40 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehab Anne Arundel Edgewater 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 D F Hours Min. (Month, Day, Year) 10/28/1936 · Virginia Yrs. Director 233-56-3131 73 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 4 Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12416 Rustic Hill Dr. 20715 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 72 hours after 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. 1956-76 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Technical Sergeant U.S. Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other traumatic and injury or other traumatic an Elmer Lucas Lenora Kitchen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fukuko Lucas / spouse 12416 Rustic Hill Dr., Bowie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 4/7/2010 4 Donation 5 Other (Specify) Crownsville, MD 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line arryThmias Immediate Cause (Final Onset and Death Cardiac Physician/ Hatal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir physician and the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ☐ Unknown detached 9 Unknown is been signed by t. 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page The performed' death? 2 🗆 No Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မ this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After the 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 6Th 20110 cym Dous3709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowle MD Fox love 20715 CHAWLA 14300 Gallent. 31. Date filed (Month, Day, Year) APR 0 8 2010 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|   |                   | Please  | Type or Pri   |                        |                            |                  |                           |   | -                                  |                        | _             | ble.  |   |
|---|-------------------|---|---|------------------------|----------------------------|------------------|---------------------------|---|------------------------------------|------------------------|---------------|---|---|
|   |                   | For State   | State of Ma   | arylar                 |                            |                  | nt of F<br>te of E        |   | Mental Hy                          | •                      | 00            |   | 12292                                   |
|   |                   | Registrar  1. Decedent's Name (First, Middle, Las   | st)   |                        | 007                        | inca             | ic or L                   | Jean  | 2. Date of D                       |                        |               |   | 3. Time of Death                        |
| Physicia<br>Medio   |                   |   | onna<br>  |                        | LePage                     |                  |                           |   | Month                              | +                      |               |   | 2:28 PM <sup>M</sup>                    |
| Examin  | ier               | 4a. Facility Name (if not institution, give   |   | 111                    |                            |                  | -                         | Location of Deatl                                 | h                                  |                        | -             |   | У                                       |
| Funeral<br>Director   |                   | 5. Social Security Number 6. S<br>215-52-5065 1   | ex 7. Age   | 61                     | last birthday)<br>Yrs.     | If Und<br>Months | er 1 Year<br>Days         | If Under 24 Hrs<br>Hours Min.                     |                                    | rth<br>av <i>Year)</i> | Ī             | Coun  | try)                                    |
|   |                   | Usual Residence of Decedent   |   |                        |                            |                  |                           |   | 1 1-0-1                            | . 747                  |               |   |   |
| laryland<br><b>ka-f sh</b><br>ified at  | ector             | 10a. State 10b. County  Maryland Montgon  | nery  |                        | ty, Town or Loc<br>ilver S |                  | ng                        |   |                                    |                        |               | 1   | 0d. Inside City Limits  1  ✓ Yes 2   No |
| with the N<br>s 23a or 28<br>ust be not   | Funeral Director  | 10e. Street and Number<br>555 Thayer Aven   | ue Apt.   | 111                    |                            | 1                | ip Code<br>0910           |   |                                    |                        | S.A.          | hat Coun  | itry?                                   |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | by                | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ※ Divorced   | 12. Was Decedent E<br>Armed Forces?<br>1  Yes 2 If Yes, Give                | ver in U.<br>No        |                            |                  |                           | ispanic Origin? (Spanic Origin, Puert<br>Specify: | pecify Yes or No<br>o Rican, etc.) | -                      |               | , White, e  | etc.                                    |
| in 72 hours<br>e.<br>nan "natura<br>Medical E   | Completed         | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Seconday (0-12)   |   | i+)                    | 16a. Deced<br>(Give k      | and of w         |                           | ation<br>during most of wor                       | rking                              | 1                      | Kind of Bus   | 3. Time of Death 2:28 PM M 2:28 PM 2:28 |   |
| ed with<br>Hygien<br>other the  | Be Co             | 17. Father's Name (First, Middle, Last)   |   |                        | Mana                       | ger              |                           | 18. Mother's Na                                   | me (First Middle                   |                        |               |   |   |
| ld be fil<br>Mental<br>arked<br>atic ev   | 2                 | James H. Davi   | s   |                        |                            |                  |                           | Marion  | , ,                                |                        |               |   |   |
| ind 2 shou<br>lealth and<br>im 27 is m  |                   | 19a. Informant's Name/Relationship (Type, Print)  Lynn Caron Sister 121 N. Manheim St. York, Pa.17402   |   |                        |                            |                  |                           |   |                                    |                        |               |   |   |
| Page 1 a<br>tment of h<br>tant: If ite<br>jury or ot  |                   | 20a. Method of Disposition    1   XBurial   2   Cremation   3   Removal from State   Crestlawn   Memorial   Pk   4/9/2010     21. Signature of Funeral Service Licensee   20b. Place of Disposition (Name of cemetery, crematory or other place)   Crestlawn   Memorial   Pk   4/9/2010   Marriottsville, Md. |   |                        |                            |                  |                           |   |                                    |                        |               |   |   |
| permit<br>Depar<br>Impor<br>any in  |                   | 21. Signature of Funeral Service Licens   | see   |                        | 76                         | . Name a         | and Addres<br>Sandy       | ss of Facility F<br>Spring                        | leck Fur<br>Road La                | nera<br>urel           | 1 Hom<br>, MD | e<br>2070   | )7                                      |
| Physician/  |                   | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only o<br>Immediate Cause (Final<br>disease or condition  |   |                        |                            |                  |                           | g, such as cardiad                                | or respiratory a                   | rrest,                 |               |   | Interval Between<br>Onset and Death     |
| Medical<br>Examiner   |                   | resulting in death)   | Due to (or as a   | a conseq               | uence of):                 | <u> </u>         |                           |   |                                    |                        |               |   | _                                       |
| uted<br>d<br>ansit  | Examiner          | Sequentially llst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events  | Due to (or as a Diabete   | a conseq               | uence of):                 |                  |                           |   |                                    |                        |               |   |   |
| e be executed<br>ysician and<br>ie burial-transit   |                   | resulting in death) Last  Due to (or as a consequence of):  Hyperlipidemia  |   |                        |                            |                  |                           |   |                                    |                        |               |   | 10 years                                |
| To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. We this certificate has been signed by the attending physici To the Luneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown                   | 2 🗌 Feta               | al death 3 🗔               | Ectopic Other (  | c pregnanc                | y   |                                    |                        |               |   | ,                                       |
| es that th<br>signed by<br>I be detac   | þ                 | Part II. Other significant conditions of  | ontributing to death b  | ut not res             | sulting in the u           | nderlying        | g cause giv               | en in Part I.                                     |                                    |                        |               |   |   |
| law requi   | Completed         |   |   |                        |                            |                  |                           |   | 24a. Was                           | s an                   | 24b. W        | ere autor   | osy findings available                  |
| an: The<br>tificate<br>tor, pag   | Be Co             | 25. Was case referred to medical  |   |                        | _                          |                  | 26. Pla                   | ace of Death (Che                                 |                                    | ormed?                 | lo 1          | ☐ Yes   | 2 □ No                                  |
| hysici<br>this cer<br>al direc  | 은                 | 1 LJ Yes 2 KJ No  |   |                        | ER/Outpatien               | t 3 🗆 I          |                           | 4 LJ Nursing F                                    |                                    |                        |               |   | )                                       |
| nding F<br>ath.<br>r: After t<br>e funera   | icate             | 27. Manner of Death  1  | 28a. Date of injui<br>(Month, Day   | y<br>(Year)            | 28b. Time of injury        | М                | 28c. Injun<br>work<br>1 🗆 | / at<br>?<br>Yes 2 □ No                           | 28d. Describe                      | how inju               | ry occurred   | I   |   |
| tal or Atters after de al Directo   | al Certificate:   | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined   | 28e. Place of Injubuilding, etc   | ry - At ho<br>(Specif) | ome, farm, stre            | et, facto        | ry, office                |   | 28f. Location<br>City or To        |                        |               | or Rural  | Route Number,                           |
| he Hospit<br>in 24 hour<br>he Funere<br>pleted filk   | Medical           | (Check 2 L Medical Exami  | sician: To the best of<br>iner: On the basis of ex<br>se Practioner: To the | kaminatio              | n and/or investi           | igation, i       | n my opinic               | n, death occurred                                 | at the time, date                  | and plac               | e, and due t  | o the cau   | use(s) and manner stated                |
| To t  |                   |   |   |                        |                            |                  |                           |   |                                    |                        |               |   |   |
| . 0   |                   | 30. Name and address of person who do   | completed cause of de   | ath (Item              | n 23a) (Type, P.           |                  | D0515                     | סמ  |                                    | 7                      | 10/           | 10  | 10                                      |
| 13  |                   | Harvey Steinfeld,   | M.D. 6131   | Sha                    | dy Sid                     | e Ro             | ad Sh                     | nady Side   | e, MD 20                           | 764                    |               |   |   |
| Stat<br>Registra  |                   | APR 0820  | 010 32. Registra  | ı s signa              | B. 4                       | ark              |                           |   |                                    |                        |               |   |   |

|  |                  | Plea  | se Type or Pri<br>State of M                             |                        |                       |   |                    |                           |                                |                            |                               | jible.            |  |
|--|------------------|---|--|------------------------|-----------------------|---|--------------------|---------------------------|--------------------------------|----------------------------|-------------------------------|-------------------|--|
|  |                  | 1 - State<br>Registrar  |  |                        | Ce                    | rtificat  | e of E             | Death                     |                                | Reg                        | . No. 2 1                     | 10                | 12893  |
| Physicia   | n/               | 1. Decedent's Name (First, Middle,  | •  |                        |                       |   |                    |                           | 2. Date<br>Mont                | of Death                   |                               | Year              | 3. Time of Death                             |
| Medic  | al               |   | NETTE  | _ ! !                  | 200                   | _   |                    |                           | 0                              | ٦                          | Day                           | 10                | 10:35 AM                                     |
| Examin   |                  | 4a. Facility Name (if not institution, 5204 421   | NO AVE   |                        |                       | H.  | YAT                | Location of De            | -E                             |                            | 4c. County<br>PRIN            |                   | edrue's                                      |
| Funeral<br>Director  |                  | 577-52-4308   | 6. Sex 7. Ag   | e (In yrs. la          | ast birthday)<br>Yrs. | Months Months                                     | Days               |                           |                                |                            | 7938                          | 9. Birthi<br>Coun | place (State or Foreign<br>etry)<br>Virginia |
| show   | 'n               | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. Cit               | y, Town or L          | ocation   |                    |                           |                                |                            |                               | 1                 | Od. Inside City Limits                       |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Hygiene. Inmportant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | -=               | Maryland Princ  | ce George's  |                        |                       |   | ttsv               | ille                      |                                |                            |                               |                   | 1 ☐ Yes 2 🏻 No                               |
| ith th   |                  | 5204 42nd Ave   | nuo.   |                        |                       | 10f. Zip  |                    | 781                       |                                | 10g                        | Citizen of                    |                   | ·  |
| eath v   | Funeral          | 11. Marital Status  | 12. Was Decedent E                                       | ver in U.S             | 3. 13.                | . Was Deced                                       | lent of Hi         | spanic Origin?            | (Specify Yes o                 | r No-                      | 1                             | ed St             |  |
| fter de  | 2                | 1 Never Married 2 Marri   | ied Armed Forces?  1 ☐ Yes 2 ☑  If Yes, Give             | No                     |                       | If Yes, spec                                      |                    |                           | ierto Rican, etc               | :.)                        | Blac                          | ck, White,        |  |
| ours a<br>ntural'  | sted             | 3 ☐ Widowed 4 🙀 Divorced  | Year or Dates.   |                        | 10.0                  |   |                    |                           |                                |                            | Specify                       |                   | hite   |
| in 72 he<br>e.<br>nan "na<br>Medic   | Completed        | (Specify only highes<br>Elementary/Seconday (0-12)  |  | i+)                    | (Give                 | edent's Usua<br>e <i>kind</i> of wo<br>DO NOT use | rk done d          | ation<br>Juring most of t | working                        | 16                         | b. Kind of B                  | usiness In        | dustry                                       |
| d with<br>lygien<br>ther ti  | a)               | 12  |  |                        | <u> </u>              | ffice   | r                  |                           |                                | $\perp$                    | Ba                            |                   |  |
| be file<br>antal H<br>ked of<br>c ever   | ᆲ                | 17. Father's Name (First, Middle, La<br>Ernest Lee  |  |                        |                       |   |                    |                           | Name <i>(First, M</i><br>Jinia |                            | <sub>den Sumam</sub><br>abeth | ,                 | .lliams                                      |
| nd Me  |                  | 19a. Informant's Name/Relationshi   |  |                        | 19b. Mai              | lina Address                                      | (Street a          |                           | -                              |                            |                               |                   | Code) 90069                                  |
| d 2 shralth a  |                  | Richard H. Dodd   | l, Jr./son   |                        |                       |   |                    |                           |                                |                            |                               |                   | ywood, CA                                    |
| of He  |                  | 20a. Method of Disposition 1  Burial 2  Cremation   |  |                        | lace of Disp          | oosition (Nar                                     | ne of              |                           | Date                           |                            | c. Location                   |                   |  |
| t. Pag<br>tment<br>tant:<br>jury c   |                  | 4 Donation 5 Other (S)  | pecify)  |                        | ıl Jou                | rney (  | Crema              | atory 4                   | 1/9/201                        |                            |                               |                   | aryland                                      |
| permit<br>Depar<br>Impor<br>Impor<br>any in  |                  | 21. Signature of Funeral Service Li   | (10) =   | M000                   | رج اؤ                 | 2. Name an  | d Addres           | s of Facility<br>Cremat   | ion Se                         | ryice                      | P.O.                          | Вох               | 784<br>MD 21029                              |
|  |                  | 23a. Part \ Enter the disease, or o   | complications that caused                                | M009                   | h. Do not en          | ever1   | y L.<br>e of dvino | Heckro                    | diac or respirate              | A. C                       | larks                         | <u> </u>          | Approximate                                  |
| hysician/  |                  | shock, or heart failure. List or<br>Immediate Cause (Final  | nly one cause on each line                               |                        |                       |   |                    |                           |                                |                            |                               |                   | Interval Between<br>Onset and Death          |
| Medical  |                  | disease or condition<br>resulting in death)   | a. Due to (or as a                                       | a consequ              | uence of):            | 2UCI)   | IR                 | PULMO                     | NARY                           | DL                         | SEAS                          | F                 |  |
| Examiner   | _                | Sequentially list conditions,   | b. CONCL   | FSTI                   | VE                    | HEA   | RT                 | FAIL                      | URE                            |                            |                               |                   |  |
| sit a  | Examiner         | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury |  |                        |                       |   |                    |                           |                                |                            |                               |                   |  |
| xecure<br>and and  | Exa              | that initiated events resulting in death) Last  |  |                        |                       |   |                    |                           |                                |                            |                               |                   |  |
| eath certificate be executed attending physician and for use as the burial-transit   | dical            |   | d  |                        |                       |   |                    |                           |                                |                            |                               |                   |  |
| ling ph  | Me               | IF FEMALE:  | 00-15  |                        |                       |   |                    |                           |                                |                            | 1                             |                   |  |
| ath ce<br>attend<br>for us   | Physician/Medica | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome  1  Live Birth 4  Pregnant a        | 2 Feta                 | death 3               | ☐ Ectopic p                                       |                    | у                         |                                |                            |                               | te of delive      | ery<br>Day Year                              |
| y the  | hysi             | 1 Yes 2 No<br>9 Unknown   | 9 Unknown  | t time or c            | JOERN 3               |   |                    |                           |                                |                            |                               |                   |  |
| requires that the de<br>been signed by the<br>should be detached   | by P             | Part II. Other significant condition  | ns contributing to death b                               | ut not res             | ulting in the         | underlying (                                      | cause giv          | en in Part I.             | 23e.                           | Did tobac                  | co use cont                   | ribute to th      | ne cause of death?                           |
| squires  | Completed by     |   |  |                        |                       |   |                    |                           | -                              | 1 🗌 Yes                    | 2 🗌 No                        | 3 🗷 Proi          | pably 4 🗌 Unknown                            |
| has be   | mple             |   |  |                        |                       |   |                    |                           | 24a.                           | Was an autopsy             |                               | prior to co       | psy findings available mpletion of cause of  |
| s certificate has bilifector, page 2 s   |                  | 25. Was case referred to medical  |  |                        |                       |   |                    |                           |                                | yes 2                      |                               | death?<br>1 🔲 Yes | 2 🗆 No                                       |
| s certi  | To Be            | examiner?  1  Yes 2 No  | Hospital:  | ant 2 🗆                | CP/Outpatie           | ent 3 🗆 DO  | Othe               | r.                        | check only one,                |                            |                               |                   |  |
| ig rny<br>ter this   |                  | 27. Manner of Death   | 28a. Date of injur                                       | ry                     | 28b. Time of          |   | 8c. Injury         | at                        | g Home 5 🔀<br>28d. Desc        |                            | njury occurr                  |                   | )  |
| eath. or: After t  | ifica            | 1 Matural 5 Pending 2 Accident Investig: 3 Suicide 6 Could n  | ation  | , rear)                | linjury               | М   | work               | Yes 2 No                  |                                |                            |                               |                   |  |
|  | Certificate:     | 4 Homicide determin   |  | ry - At ho<br>(Specify | me, farm, st          | reet, factory                                     | , office           |                           |                                | ion (Street<br>or Town, St |                               | er or Rural       | Route Number,                                |
| tospita<br>4 hours<br>uneral<br>ed filled  | Medical          | 29a. Certifier 1 Certifying (Check 2 Medical Ex   | Physician: To the best of<br>kaminer: On the basis of ex | my knowl               | edge, death           | occured at  | the time,          | date and place            | e, and due to t                | ne cause(s                 | s) and mann                   | er as state       | d.   |
| vithin 2.  |                  | only one) 3 Certifying  29b. Signature and title of certifier   | Nurse Practioner: To the                                 | best of my             | knowledge,            | death occur                                       | red at the         | time, date and            | place, and due                 | to the cau                 | use(s) and ma                 | anner as st       | ated.  |
| 2 3 4 8  |                  |   | 1  |                        | MD                    |   |                    |                           | 12                             | 29d.                       | Date signer                   | 1 .               |  |
| 5  |                  | 30. Name and address of person w  | who completed cause of de                                | eath (Item             |                       | Print) (2   | H T                | 08680<br>moriz            | AVE                            |                            | 7419                          | 21/2              | 010  |
|  |                  | ARUNDEHALAM   | SEVICITA   | 43                     | 5804                  | HY  | ATT.               | SVILLE                    | 7, Mi                          | > ~-                       | 207                           | 8)                |  |
| State<br>Registra  |                  | 31. Date filed (Month, Pay Year)  | 2 2010 32. Registra                                      | r's Signat             | ure A                 | back  |                    |                           |                                |                            |                               |                   |  |
| negistia   |                  |   |  |                        | 1. 6                  | 7   |                    |                           |                                |                            |                               |                   |  |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 22/9 PM **Physician** Apri 05,2010 LEONA M. MILLS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester Cambridge General Hospita Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 F 7/17/1921 MARYLAND 88 220-01-5942 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Maritial Exprising to use the notified at once. 1 ☐ Yes 2€ No Director CAMBRIDGE MARYLAND DORCHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21613 1252 HUDSON RD. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2√2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. þ WHITE 3€ Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER BANKING** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARGUERITE HURLEY LUKE H. MESSICK, SR. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HERBERT H. MESSICK / NEPHEW 14 MERRYWEATHER DR., CAMBRIDGE, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/9/2010 CAMBRIDGE, MD DORCHESTER MEMORIAL PARK 22. Name and Address of Facility 21. Signature of Funeral S CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in the light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician the for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav Year in the past 12 months?
1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 25 No 2 No 1 TYes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 RER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 W Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Hospital

State Registrar

completely

5

(Check only one)

voens

29b. Signature and title pf certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wanda Ashendorf Maltz 5:30 A. M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3114 Gracefield Road #501 Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Y 1 □ M 2 □XF 97 Months Davs Hours 052-05-0700 Director New vork Usual Residence of Decedent an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring Montgomery 1X Yes 2 ☐ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 3114 Gracefield Road # 501 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. ð 1 Never Married 2 Married Yes 2 X No. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify:White Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 | h and Mental Hygiene, 7 is marked other than "n life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical other traumatic event, the Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Solomon Ashendorf Rachel Rae Ashendorf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Daniel N. Maltz/Son 95 N. Princeton Circle, Lynchburg, VA 24503 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Nash. University

edical center ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ ALZHEIMER S disease or condition resulting in death) DISEASE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death ned by the ai 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cerebrovascular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Records, Completed coronary artery disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No Division of Vital ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ဥ 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Matural 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

MD

3110 Gracefield Rd Silver

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:35 p William . Lafavette **McCamey** April 8, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country ifornia 1 X M 2 □ F Months Days Hours Min. Dec. Month 22 Pay, 1931 539-30-3748 78 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral USA 23a 7213 Ridgewood Avenue 20815 items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ö þ 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 1959-61 "natural". 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry uld be filed within , \_\_\_\_d Mental Hygiene. \_\_\_\_ther than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Treasury Dept. International Economist marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tillman Calvin McCamey Vera Clementine DeMars and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7213 Ridgewood Avenue, Chevy Chase, MD 20815 2 Hiroko McCamey/Wife Page 1 and 2 sl ment of Health a ant: If item 27 is 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or of Metropolitan Crematory 1 Durial 2 X Cremation 3 Removal from State April 10, Alexandria, VA 4 Donation 5 Other (Specify) 21. Signat / e o Funeral/Service Licensee <sup>2</sup>? Name and Address of Fights Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or or shock, or heart failure. List on on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani End-Stage Liver Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Medical 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? jo Month Year Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 XUnknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed' within 24 hours after death.

To the Funeral Director; After this certificate the Completed filled in by the funeral director, page 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TXNo ျ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending work's 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) APR 12 2010 Registrar's S

Sujoy Tagore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, MD 20816

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April 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ OT Day 2010 6:00 pM Norman Moglen Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Sunrise Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday, **Funeral** New York Days 1 🛛 M 2 🗆 F 0871271920 125-07-9180 Director 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Silver Spring Montgomery <u>Maryland</u> 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number Funeral 302 Dale Drive 20910 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Yes 2 X No Specify: WWII 3 Widowed 4 Divorced White. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Geologist U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bella Kurland Joseph Moglen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Birch Pond Lane, Fairfax, Virginia 22033 Gail Frola - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Lincoln Crematory 04/09/2010 Brentwood, Maryland 4 Donation 5 Other (Specify) Ft. 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 21. Signa ure di Funeral Service Licensee atu Chele 11800 New Hampshire Ave., Silver Spring, MD 20904 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebral Vascular Accident disease or condition Medical resulting in death) Examiner Arteriosclerotic Cerebral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events septimized by the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, if any, leading the conditions, if any, leading the conditions, if any, leading to immediate cause of the conditions, if any, leading to immediate cause of the conditions of t Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Adult Failure to Thrive Syndrome Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death sate has been signed by the page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Depression 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or which the fundation of the Fundation of the Fundation of the fundation o performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Other: Certificate: To 1 🔲 Yes 2 🗶 No 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA iving 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No

Accident Investigation Suicide 6 Could not be 3 ☐ Suicide4 ☐ Homicide determined

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier

28f. Location (Street and Number or Rural Route Number,

City or Town, State,

D0055522

April 9, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, Maryland 20910 MD. Robert H. Gerard, 31. Date filed (Month, Day, Year) APR 12 2010 Registrar's Signature

State Registrar

Medical

29a. Certifier

only one)

U

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Moore Month Year **Physician** 8:26 PM Robert April 2010 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year 12/22/1940 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthdey) **Funeral** 1 XXM 2 □ F 69 Director 162-32-3549 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2XXNo PA Director York Spring Grove 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 23a 1945 Rose Pointe Way 17362 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No
If Yes, Give Year or Dates: 63 -65 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o, 1 ☐ Yes 2XXNo Specify: White Specify ≥ 3 Widowed 4 Divorced 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7 is marked other than traumatic event, the Me District Manager Pest Control 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert A. Moore Eleanor Rowe 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Linda B. Moore – Wife 1945 Rose Pointe Way, Spring Grove, PA 17362 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Kenworthy Funeral Home, Inc. 4/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Hanover, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 269 Frederick Street CC0354 Kenworthy Funeral Home, Inc. Hanover, PA 17331 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to or as a consequence of cell disease or condition resulting in death) /Medical as a consequence of) **Examiner** Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Linknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA ည 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

15.

State Registrar

Medical

(check only

29b. Signature and title of certifier

aithe

29c. License number RES-000

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tatthew oneman 600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year) 32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                | 1 - For<br>State<br>Registrer  | State of Ma   | ryland / Depa<br><i>Cei</i>                        | artment of I<br>rtificate of                                   |  |   | giene<br>Reg. No. 0 | 0  | 12899  |  |  |
|--|----------------|--|---|--|--|--|---|---------------------|--|--|--|--|
| Physici  | ian            | Decedent's Name (First, Middle, Last)     NOEL B. MARNANE  |   |  |  |  | 2. Date of Dea<br>Month<br>APRIL            | 7, 2010             | Year   | 3. Time of Death                                     |  |  |
| /Medi<br>Examir  | cal            | 4a. Facility Name (If not institution, give  | street and number)  |  | 4b. City, Town,  | or Location of Death                                     |   | 4c. County          | of Death   | 7:05 p™  |  |  |
| LAdiiii  | lei            | 6808 SUNSET DRIVE  |   |  | LAYTONS  |  |   | MONTGO              |  |  |  |  |
| Funeral<br>Director  |                | 5. Social Security Number 6. Security 579–50–9026  | 7. Age  | (In yrs. last birthday)<br>71 Yrs.                 | If Under 1 Year<br>Months Days                                 |  | 8. Date of Birth<br>(Month, Day<br>Dec . 2! | /, Year)            |  | lace (State or Foreign<br>try)<br>chigan             |  |  |
| pur *  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town or Lo                              | cation   |  |   |                     | 11   | 0d. Inside City Limits                               |  |  |
| Maryla<br>f shor   | tor            | Md. Montgom  |   |  | nsville  |  |   | 1 XYes 2 □ No       |  |  |  |  |
| death with the Maryland<br>ms 23a or 28a-f show<br>Imust be nutified at  | Director       | 10e. Street and Number   |   | 10f. Zip Code                                      |  | 10g. Citizen of W  | log. Citizen of What Country?               |                     |  |  |  |  |
| ath wi   | rai            | 6808 Sunset Drive  |   |  |  | 882  |   |                     | United States  14. Race - American Indian,                           |  |  |  |
| within 72 hours after de<br>ene.<br>then "natural", or items<br>he Medical Examinal in   | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  | 12. Was Decedent Endemed Forces? 1 ☐ Yes 2 ▼ Note of Pear or Dates:   | 0  | Was Decedent of Information of Yes, specify Cub<br>1  Yes 2 No | Hispanic Origin? (S<br>an, Mexican, Puert<br>Specify:    | pecify Yes or No-<br>o Rican, etc.)         | Specify:            | k, White,  |  |  |  |
| 72 hou<br>natura<br>iical E  |                | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |   |  |  |  |   | 16b. Kind of Bu     | siness/Inc   | iustry   |  |  |
| vithin 72 hours af<br>ne.<br>han "natural", or<br>e Medical Exam   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+   | .)   |  | tive Assi  |   | Non-Pro             | fit  | Organizatio  |  |  |
| lled<br>her<br>ht.   | Be             | 12 17. Father's Name (First, Middle, Last) Louis Beaupre   | 2   |  |  | 18. Mother's Nan   | me (First, Middle,<br>na Petri              |                     |  |  |  |  |
| d 2 should be full and Mental P  | 은              | 19a. Informant's Name/Relationship (Ty   | pe, Print)  | 19b. Mailin  | ng Address (Street   | and Number or Ru   | ıral Route Numbe                            | r, City or Town,    | State, Zip   | Code)  |  |  |
| and 2<br>salth a<br>n 27 is  |                | Aileen O'Connell   | / Daughter  |  |  | Drive, La  |   |                     |  | 882  |  |  |
| Pages 1<br>ent of He<br>nt: If iten<br>ry or oth   |                | 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ R  | lemoval from State  | 20b. Place of Dispo<br>cemetery, cren              | sition (Name of<br>natory or other pla                         | 1  | Date  | 20c. Location -     | City or To   | wn, State  |  |  |
| rmit. Pa<br>partmen<br>portant:<br>y injury  |                | ' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License   | 9A  | Metropol   | itan Cre   |  | 13/10                                       | Alexan              | dria   | , Va.  |  |  |
| Depariment Important   |                | Dayw. 6  | Baule   | ~   "  | ${	t Muriel}$  | H. Barber<br>Box 5038,                                   | Funeral                                     | l Home              | Mđ. :  | 20882  |  |  |
|  |                | 23a, Part1. Enter the disease, or complished, or heart failure. List only or   | cations that caused the cause on each line  | the death. Do not ent                              |  |  |   |                     |  | Approximate<br>Interval Between                      |  |  |
| Physician  | 0 .1           | Immediate Cause (Final disease or condition resulting in death)  | A   | othorax  |  |  |   |                     |  | Onset and Death 6 months                             |  |  |
| /Medical<br>Examiner   |                | resoluting in docum)   | Due to (or as a   | consequence of):                                   |  |  |   |                     | ^  |  |  |  |
|  | Jer            | Sequentially list conditions.  |   |  |  |  |   |                     |  |  |  |  |
| ecuted<br>and<br>-transi   | Examiner       | cause. Enter Underlying Cause (Discase or injury that initiated events resulting in death) Last  |   |  |  |  |   |                     |  |  |  |  |
| icate be executed<br>physician and<br>s the burial-transit   | a E            | resulting in death) Last  Due to (or as a consequence of):   |   |  |  |  |   |                     |  |  |  |  |
| fficate<br>g phys<br>as the  | edical         |  | l   |  |  |  |   |                     | Ì  |  |  |  |
| death cert<br>a attending<br>d for use   | Physician/Me   | in the past 12 months?   | Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify) |  |  |  |   |                     | te of delivery<br>onth Day Year                                      |  |  |  |
| at the   | hys            | 9 🗆 Unknown  | 9 □ Unknown   |  |  |  |   |                     |  |  |  |  |
| The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit               | þ              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco                                   |   |  |  |  |   |                     | cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown |  |  |  |
| sicien: The law r<br>certificate has be<br>irector, page 2 sh  | Completed      |  |   | <del></del> -                                      |  |  | 24a. Was a<br>autop<br>perfor<br>1 ☐ Yes    | sy p<br>med/2 d     | Vere autor<br>rior to cor<br>leath?<br>Yes                           | psy findings available inpletion of cause of<br>2 No |  |  |
| icien:<br>certific<br>ector,   | Be             | 25. Was case referred to medical examiner?   | lospital:   |  | 0+   | nor  | ath (Check only or                          |                     |  |  |  |  |
| To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page | tion; To       | 27. Manner of Death  1 Natural 5 Pending   | 1  Inpatien<br>28a. Date of Injury<br>(Month, Day   |  | 28c. Inju  | ry at  | lome 5 Resid<br>28d. Describe h             | ence 6 Othe         |  | 9  |  |  |
| or Attenation after deat<br>Director:  | Certification; | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | eet, factory, office  | 1000   | 28f. Location (S<br>City or Tow                                | (Street and Number or Rural Route Number,<br>own, State) |   |                     |  |  |  |  |
| e Hospite<br>124 hours<br>le Funerel<br>letely filled  | Medical C      |  |   | f my knowledge, death<br>examination and/or inved. |  |  |   |                     |  |  |  |  |
| To th<br>within<br>To th<br>compl  | Me             | 29b. Signature and title of certifier  |   |  | 29c. Licen   |  |   | 29d. Date signed    | (Month,  | Day, Year)   |  |  |
|  |                | - Composition  | auln  | wo   | 0  | 53424  | F   | Joseph              | 8  | 2010   |  |  |
| 12   |                | 30. Name and address of person who co<br>Edward P. Taubman   |   | ath (Item 23a) (Type,<br>18109 Pr                  | Print)<br>ince Phi   | lip Drive  | e, #275,                                    | Olney,              | Md.  | 20832  |  |  |
| Sta<br>Regist  |                | 31. Date filed (Month, Day, Year) APR 12   | 32. Registrar   | 's Signature                                       | parker   | ,  |   |                     |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mitchell Morton April 2ď10 10, P M 8:57 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1037 Lindfield Drive Frederick Frederick Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Months Days Hours Min. 218-58-1425 60 **Director** December 12, 1949 Washington DC Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1037 Lindfield Drive 21702 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 No 1968-Maryland 21215-0036 If Yes, Giv 1 ☐ Yes 2 X No Specify: 1979 Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ift. Page 1 and 2 should be lited in artment of Health and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Information Technology Censiis 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Harrod Morton June Evelyn Mitchell a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belinda Morton / Wife 1037 Lindfield Drive, Frederick, Maryland 21702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of I 1 Burial 2 X Cremation 3 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) Smithsburg Crematory Apirl 14, 2010 Smithsburg, Maryland . Signature of Funeral Service Licer 2. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 Fast Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ASPINATION disease or condition resulting in death) NEUMONIA On Medical Due to (or as a consequence of): Examiner 98415 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě DISORDER Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? CEREBRO. UNIEULAR 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MEDICAL DIRECTOR

State

31. Date filed (Month, Day, Year,

Registrar
DHMH 17 Rev 7/2009

516

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mrocal

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32. Registrar's Signature

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DIRECTOR

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FLEDERICK CE

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Gordon Allen Mallonee April 05, 2010 11:11 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F 216-28-0266 19,1930 Maryland Dec. Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 1084 Sun Valley Drive USA 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1951-1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1972 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Air Force 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Mallonee Hilda Raap 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Mallonee / Wife 1084 Sun Valley Drive Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, MD 2010 Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 🗆 No 2 🔲 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending

b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
P Funeral Director: After this certificate has been signed by the attending physician and and burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the the be detached ģ signed page 2 should director, filled in by

**Physician** 

Examiner

**Funeral** 

**Director** 

28a-f show

23a or

itеms

'natural", or

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the "Medeone.

**Physician** 

Examiner

/Medical

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

þ

Completed

Be

Certification: To

Medical

30. Name and address of person

event, the Medical Examinar must be notified at

/Medical

2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Mgnth, Day, Year)

To the I within 2 To the I

State Registrar 31. Date filed (Month, Day, Year 32. Registrar's Signature APR 0 8 2010

ted cause of death (Item 23a) (Type, Prin

Amend #1, per MD g903 5/10/10 TT/#17perFH. G904 6/11/2010 WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/  $20^{\text{Year}}_{10}$ Dorris Marrisett 2223 Dorris S: Marrisette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2X F (Month, Day, Tan 5 Months Days Hours Arkansas 429-32-9927 86 Director 1924 Jan Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Chevy Chase 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 USA 8100 Connecticut Ave Apt 1411 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Black 3 ₩ Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) New York Elementary/Seconday (0-12) College (1-4 or 5+) 12th Public School's 6yrs Librarian Be 17. Father's Name (First, Middle, Last)

Jake Stewart 18. Mother's Name (First, Middle, Maiden Surname) ပ Hannah Suttle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chevy Chase, Md. 20815 Wilma Coble(Niece) 9016 Levelle Dr. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran 4-13-10 | Crownsvil | Winner of Recessor Falls Sons Mortuary, P.A. Crownsville, Md. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Jarry B. Bes M20483 23a. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ VENTRICULAR FIBRILLATION disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any leaving to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year 1 Yes 2 Dunknown סמנפ nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 🕏 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy autopc, performed death? Director: After this certificate 1 ☐ Yes 2 🗷 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{\text{\text{Nursing Home}}} \) 1 Residence 6 \( \text{\text{\text{Other}}} \) Other (Specify) မ 1 Inpatient 2 R/Outpatient 3 DOA 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5  $\square$  Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide
Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Prectioner To the best of my knowledge death promined at the time, date and place, and due to the name (s) and manner as states 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (was, una 00057124 4/6/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trunong Bao 8600 Bethesda Georgetown 31. Date filed (Month, Day, Year) State APR 07 2010 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |  |              | for State of State of Registrar  | Maryland / De<br>C             | epartment of F<br>Pertificate of D              |                                | , ,                      | iene<br><sub>eg. No.</sub> 2 0   ( | 12903  |
|--|--|--------------|--|--------------------------------|---|--------------------------------|--------------------------|------------------------------------|--|
|  | Physicia   | n/           | 1. Decedent's Name (First, Middle, Last)   |                                |   |                                | 2. Date of Deat<br>Month | h                                  | 3. Time of Death                                 |
| Ĺ.   | Medic  | al           | Karen Sue Miller  4a. Facility Name (if not institution, give street and numb      |                                | 4b City Town or                                 | Location of Death              | April                    | 9 Day Year Year 4c. County of Dea  | 2:20 A M   |
| أسد  | Examin   | er           | Casey House  | ,                              |   | ville                          |                          | Montg                              |  |
|  | Funeral  |              | 5. Social Security Number 6. Sex 7   | Age (In yrs. last birthda      | y) If Under 1 Year<br>Months Days               | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth         | 9 Bi                               | rthplace (State or Foreign                       |
|  | Director   |              | 215-52-9938 Usual Residence of Decedent  | 57 Yrs                         |   |                                | Dec 11,                  | 1952                               | Ohio Ohio  |
|  | show   | tor          | 10a. State 10b. County   | 10c. City, Town or             | Location  |                                |                          |                                    | 10d. Inside City Limits                          |
|  | Mary<br>28a-1<br>notifie   | Director     | Maryland Montgomery  |                                | Gaithersbur                                     | :g                             | -                        |                                    | 1 🗆 Yes 2 😾 No                                   |
|  | ith the  | ral          | 10e. Street and Number  33 Nancy Place Apt 1                                       |                                | 10f. Zip Code<br>208                            | 277                            | 1                        | 10g. Citizen of What C<br>United   |  |
|  | eath w   | Funeral      | 11. Marital Status 12. Was Decede  | ent Ever in U.S. 1             | Was Decedent of His                             | spanic Origin? (Spe            | ecify Yes or No-         | 14. Race - Am                      |  |
| 36   | ifter d<br>", or if  | þ            | Armed Force  1 Never Married 2 Married 1 Yes 2  If Yes, Give                       |                                | If Yes, specify Cubar  1 ☐ Yes 2 🔀 No           |                                | Rican, etc.)             | Black, Whi                         |  |
| Ö  | atural   | Completed    | 3 Widowed 4 Divorced Year or Date  |                                | cedent's Usual Occupa                           |                                |                          |                                    | hite   |
| 215  | in 72 h<br>e.<br>nan "n<br>Medi  | lduc         | (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4    | (Gi                            | ve kind of work done d<br>. DO NOT use retired) | uring most of work             | ing                      | 16b. Kind of Business              | sindustry  |
| 2  | d withi  | Be Co        | 12   |                                | tified Nur                                      |                                |                          | Health                             | care   |
| anc  | be file<br>ental +<br>ked of<br>c ever   | To B         | 17. Father's Name (First, Middle, Last)  Clyde Miller                              |                                |   | 18. Mother's Nam               |                          | ,                                  | an   |
| ary  | hould<br>and Me<br>s mar<br>umati  |              | 19a. Informant's Name/Relationship (Type, Print)                                   | 19b. Ma                        | ailing Address (Street a                        |                                |                          |                                    |  |
| Σ  | nd 2 s<br>ealth a<br>m 27 i  |              | Terri Michelle Miller/d  | aughter 525                    | Casey Lan                                       | e Rockv                        | ille, Ma                 | ryland 208                         | 50   |
| ore  | ge 1 au<br>it of H<br>: If itel<br>or oth  |              | 20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 ☐ Removal from S             |                                | sposition (Name of<br>rematory or other place   | e)                             | Date                     | 20c. Location - City o             | r Town, State                                    |
| Baltimore, Maryland 21215-0036   | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |              | 4 Donation 5 Other (Specify)  21. Since the of Funeral Service Licenses            |                                | ourney Crem                                     |                                |                          | Woodbine,                          |  |
| Ba   | Dep<br>Imp<br>any  |              | nuanita Ryhoman  | M00957                         | Going Home<br>Beverly L.                        | Crematic<br>Heckrot            | on Servio<br>te, P.A.    | ce P.O. Bo<br>Clarksvi             | x 784<br>lle, MD 21029                           |
| 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |              |  |                                |   |                                |                          | Approximate<br>Interval Between    |  |
|  | Physician/<br>Medical  |              |  | Stage Live                     | r Disease                                       |                                |                          |                                    | Onset and Death                                  |
|  | Examiner   |              | Due to (or   | as a consequence of): atitis C |   |                                |                          |                                    |  |
|  |  | iner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying |                                | <del>-</del>                                    |                                |                          |                                    |  |
|  | cuted<br>and<br>transit  | Examiner     | Cause (Disease or iinjury that initiated events c                                  |                                |   |                                |                          | <del></del>                        |  |
|  | certificate be executed inding physician and use as the burial-transit   | edical E     | resulting in death) Last Due to (or  | as a consequence of):          |   |                                |                          |                                    |  |
| 3760   | ficate<br>g phys<br>as the   |              | d  |                                |   |                                |                          |                                    |  |
| 89<br>×  | th certi<br>tendin<br>or use   | ian/f        |  | th 2 Fetal death 3             |   | /                              |                          | 23d. Date of de                    |  |
| Box  | law requires that the death certific<br>nas been signed by the attending I<br>s 2 should be detached for use as  | Physician/M  | 1 ☐ Yes 2 ☐ No 4 ☐ Pregna<br>9 ☐ Unknown 9 ☐ Unknown                               |                                | 5 ☐ Other (specify)                             |                                |                          | Month                              | Day Year   |
| P.O.   | that the<br>ned by<br>detac  | by Pr        | Part II. Other significant conditions contributing to dea                          | th but not resulting in th     | e underlying cause give                         | en in Part I.                  | 23e. Did tob             | acco use contribute t              | o the cause of death?                            |
| ds,  | quires<br>en sigi<br>ould be   |              |  |                                |   |                                | 1 □ Ye                   | es 2 🗆 No 3 🗆 F                    | Probably 4 \textbf{Y} Unknown                    |
| S  | law re<br>has be<br>e 2 sho  | Completed    |  |                                |   |                                | 24a. Was an autops       | y prior to                         | utopsy findings available completion of cause of |
| ¥  | n: The<br>ficate<br>or, pag  |              | 25. Was case referred to medical   | -                              | 00 81   |                                | perform                  |                                    | s 2 No   |
| VIta   | ysicia<br>is certi<br>directo  | To Be        | examiner?  | patient 2 ER/Outpat            | Othe  | r: 4 Nursing He                |                          | nce 6 🕏 Other (Spe                 | ify)Hospice IPU                                  |
| ō  | ing Ph<br>ifter thi  |              | 27. Manner of Death 28a. Date of   |                                | e of 28c. Injury<br>work?                       | at                             | 28d. Describe hov        |                                    | ""IOSPICE TEC                                    |
| Sion   | ttendi<br>death<br>stor: A<br>the fi   | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be                                  | Injury - At home, farm,        |   | Yes 2 □ No                     | 006                      |                                    | mat Davida Niverbar                              |
| Division of Vital Records,   | al or A<br>s after<br>I Direction by   |              |  | etc. (Specify)                 | street, factory, office                         |                                | City or Town,            | reet and Number or Ru<br>, State)  | irai noute Numbei,                               |
| The state of the s |  |              |  |                                |   |                                |                          |                                    |  |
|  | o the Prithin 2 orthe Properties   | ¥            | only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier  |                                |   | time, date and place           | e, and due to the        |                                    | s stated.  |
|  | ⊬ s ⊨ ó  |              | Dune R. O.   | + CRA                          |   | 5108                           |                          | April 9,                           |  |
|  | 7  |              | 30. Name and address of person who completed cause                                 | of death (Item 23a) (Type      | <del></del>                                     | <u> </u>                       |                          |                                    | _  |
|  | 3  |              | Diane Ruckert, CRNP 600  | Muncaster                      | Mill Road                                       | Rockvi]                        | le, Mary                 | zland 2085                         | 5  |
|  | Stat<br>Registra   | e<br>ir      | 31. Date filed (Month, Pay Year) 2 2010 322 e9                                     | strar's Signature              | back  |                                |                          |                                    |  |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 09, McElhaney Eltan 0007 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Hospital Cheverly  $\mathbf{PG}$  Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral X**M 2 □ F Hours 12/21/1961 Director 246-13-9382 N. C. 48 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD  $\mathbf{PG}$ Upper Marlboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9706 Cheakwood Drive 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify Black Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)
2 years Elementary/Seconday (0-12) Security D.C. Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jasper McElhaney Doris Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaToya Ramsey - Daughter 6829 Winners Drive; Whitsett, North Carolina 27377 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Oakwood Cemetery 04/17/2010 Salisbury, N. Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signatu Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part I. Enter the disease, or complication is that caused the death. Do not enter the mode of dying, such as cardia shock, of heart failure. List only one paulie on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Inpatient 2 🦹 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

3 2010

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FLORRINE MC QUEEN APRIL . 58 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 1 🗆 M 2 🕱 F Months Days Hours Min. 2/14/1935 Washington, DC 248 62 2312 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 √Yes 2 □ No Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20011 United States 4901 Illinois Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private <u> Housewife</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Boatwright Hattie Lee Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Mc Queen / Husband 4901 Illinois Ave. NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Suitland, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOPULMONARY ARREST disease or condition resulting in death) Due to (or as a consequence of) ASPIRATION PNEUMONIA Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lot as a conseduence on CVA Due to (or as a consequence of): ATHEROSCLEROSIS 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 X No Year Month Day Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No 2 3 No

Physician/ Medical Examiner Examiner

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Physician/Medical

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Certificate:

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page 2 s

funeral director,

within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

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**Examiner** 

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Medical

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permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic even once.

hours after death with the Maryland

Baltimore, Maryland 21215-0036

that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant g Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Tes 2 🔀 No 27. Manner of Death 1 X Natural 5 Pending Accident Investigation

Suicide

4 Homicide

29a. Certifier

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of (Month, Day, Year) injury

building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No

26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier

6 Could not be

determined

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Varnum St # 302 NE WAShington Pc 200/7 PARVEZ 1160 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2010 Month Peggy JoAnn Neely April 4 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2013 St. Bernadines Way Capitol Heights Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🖾 F Months Min Hours 242-82-5891 Director 61 1948 May 6. North Carolina Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Capitol Heights Prince George's 1 X Yes 2 No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 2013 St. Bernadines Way United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc 1 🖾 Never Married 2 🗌 Married þ Specify: Black 1 ☐ Yes 2 A No Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dorothy Becote Neely Jonas Winslow Neely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 St. Bernadines Way Capitol Heights, Md. Paula R. Neely/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 21. Signature of Funeral Service Declared 4 Donation 5 Other (Specify) Cedar Hill Suitland, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Malignant Neoplasm Bronchus, Lung resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death?

Physician. Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Eventines mand to a contract the medical Eventines.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit funeral director,

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25. Was case referred to medical

2 X No

5  $\square$  Pending

Investigation

determined

6 Could not be

examiner? 1 Tes

27. Manner of Death

1 Natural

Accident

Suicide

4 Homicide

only one)

29a. Certifier

Division of Vital Records, P.O. Box 68760 signed by the a e Hospital or Attending Physician: The I 124 hours after death. e Funeral Director: After this certificate h completed filled in by the

within 2 To the 1

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number H 66665 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Dona Leskuski, DO 9200 Basil Court Suite 200 Largo, Md.

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of injury (Month, Day, Year)

April 7, 2010

26. Place of Death (Check only one)

Other:

1 Yes 2 No

\*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at

work

20774

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

2 X N

Yes

4 Nursing Home 5 A Residence 6 Other (Specify)

City or Town, State)

28d. Describe how injury occurred

1 Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:20 9 Alice M. Nellis April 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 17 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 264-26-9428 May 88 South Carolina Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location show er than "natural", or items 23a or 28a-f sho . It a Medical Expositor must be notified at NC Moore Pinehurst 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 375 Pinehurst Trace Drive 28374 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Estaulirst once. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James McDermon Annie Mae McLendon ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald J. Nellis - husband 375 Pinehurst Trace Dr., Pinehurst, NC 28374 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/2010 Alexandria, VA Everly Crematory 4 ☐ Donation \_5 ☐ Other (Specify) 21. Signature Fineral Service Licensee 22. Name and Address of Facility Everly Wheatley Funeral Home 1500 W. Braddock Rd., Alexandria, VA 22302 -M01453 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HEMORR HAGE SUBARACHNOID /Medical Due to (or as a consequence of): Examiner CEREBRAL ANDURYSM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed TYPE DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed certificate Division of Vital 1 □Yes 2 DNo 1 ☐ Yes 2 ☐ No spital or Attending Physician: Theoris after death.
neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🖺 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00064986 MD

State Registrar 7503

32. Registrar's Signature

Surratts Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ELIZABETH AMREIN NAU APRIL 20 2010 00:05 a<sup>M</sup> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTER RIVER HOSPITAL KENT CHESTERTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APRIL 16 1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2X F 217-26-7160 81 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show or than "natural", or Items 23a or 28a-f shows the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD KENT KENNEDYVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12655 AUGUSTINE HERMAN HWY 21645 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner once. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE Specify. ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOWARD AMREIN ESTHER PHIPPS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA MILLER (daughter) 12797 AUGUSTINE HERMAN HWY. KENNEDYVILLE, MD. 21645 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4/23/10 4 ☐ Donation 5 ☐ Other (Specify) Galena Cemetery Galena, MD 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech 21. Signature of Funeral Service MUU510 118 West Cross St. Galena, MD. 21635

Stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) Physician Myocardial Infarction hours /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🔀 No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ director, page 2 should be Rectal Carcinoma Resected 1 Tyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Insulin Dependent Diabetes autopsy performe 1 Yes 2 XNo 25. Was case referred to medical examiner?
1 □ Yes 2 □ No DOCUMO Hospital: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ★ Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1). 400 S. 32. Registrar's Circ Paul R. Johnson, M.D. Cross St. Chestertown, MD. 21620 31. Date filed (Month, Day, State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April  $1^{\text{Day}}$ 2010 Medford James Pritchett 2:57 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 5, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** NF™ 2□ E Mary Land 220-10-6802 94 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinating that be notified at Director Dorchester Toddville 1 Tyes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1915 Bishops Head Road 21672 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter Black, White, etc. 3altimore, Maryland 21215-0036 1 Never Married 2 Married ģ WWII 1 ☐ Yes 2 🔼 No Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) waterman seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Pritchett Hattie Slacum ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traun once. Frances M. Pritchett wife 1915 Bishops Head Road, Toddville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4/17/10 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD re of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Ceuse (Final **Physician** adeno cara no ma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 298 Sequentially list conditions, it any localing of innectation cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a I be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ icate has been si 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 2 No certificate l 1 □Yes 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation in 24 hours area. the Funeral Director. After Funeral Director. After Funeral Director. 2/ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 0

State Registrar

DHMH 17 Rev 1/2001

100 Bramb

32. Registra 's Signature

Cambridge MO

Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death APT1 8, 2010 **Physician** 9:30 Ам Julia Howard Porter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carrol1 Westminster Summerville at Westminster If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth June 28 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 80 Yrs Director MD 217-26-8350 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene. Important: If item 223a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is a confired at any injury or other traumatic event, It a Modical Expansion and a confired at any once. 1 ⊈Yes 2 □ No **Funeral Director** Carroll Westminster MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 U.S.A. 45 Washington Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Nas Decedi... Armed Forces? 1 ☑ Yes 2 ☐ No 1953-Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. ģ 3 Widowed 4 Divorced 1982 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Captain/Nurse Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Goldley ၉ William Howard, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Slacum - Niece 5250 Black Rock Rd., Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremations 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/9/2010 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. polo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Onset and Death mmediate Cause (Final atherosc 25M **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the burial-tran Hospital or Attending Physician: The law requires that the death certificate be exect 24 hours after death. Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours after deatl To the Funeral Director; WJL 6+IVA

State

Medical

29a. Certifier (Check only one)

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Westminster

29c. License number

H0061206

Tracie L. Ryberg.

29d. Date signed (Month, Day, Year)

D.O. 2/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Month APRIL Physician/ 2:55 P M THOMAS POWELL RAYMOND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min Days Hours 1X M 2 | F Jamon 30°, 1°9°24 Maryland 86 **Director** 217-18-7155 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Frederick Frederick Maryland 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21702 10632 Powell Road 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 

No If Yes, Give 

TT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
White 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify Year or Dates. WW II Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lime Company Purchasing Agent 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stull Leona Powe11 Kuhlman Luther 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10632 Powell Road, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Ruth Powell/Wife Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1XXBurial 2 Cremation 3 Removal from State Lewistown, MD 4/11/2010 Mt. Prospect Cem. 4 Donation 5 Other (Specify) Stauffer Funeral Home, PA 21. Signature of Funeral Service I 22. Name and Address of Facility Opossumtown Pike, Frederick, MD 21702 1621 art 1. Enter the disease, or compli-shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 90 Physician disease or condition resulting in death) Medical Due to (or as cor sequence of): Examine Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal dea 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Dunknown 1 Yes within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: → Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 12 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day, Year State Bresch Registrar

# Box 68760 Baltimore, Maryland 21215-0036

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 201Ö 8 Mary Platt April 2101 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Frederick Somerford Assisted Living <u>Frederick</u> 8. Date of Birth (Month, Day, Year) May 26, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏝 F Months Davs Hours Min. New York Director 080-18-8363 84 May Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 23a or 10g. Citizen of What Country? Funeral filed within 72 hours after death with 2100 Whittier Drive 21702 United States items : 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married "natural", or White 1 ☐ Yes 2 X No Specify: Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 12 Associate Buyer Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fidelio Santos Ines Perera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Rourk / Granddaughter 214 Challedon Drive Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 and Department of F Page 1 1 🖾 Burial 2 🗌 Cremation 3 🗀 Removal from State any injury or April 4 Donation 5 Other (Specify) , 2010 New Prospect Cemetery Pine Bush, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the classes, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Day Pregnant at time of death the 9 Unknown detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Cancor 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 1 Yes Yes 25, Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After t Living FORL the Hospital or Attending Natural Accident 5 Pending 1 Yes 24 hours after death. Funeral Director: A 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. id litle of certifie 29b. Signatu Name and address of person who completed cause of death (Item 23a) (Type, Print) trederic 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 8, Mary S. Paunil 2010 9:40 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛱 F Months 579-24-9854 87 DeConth 25ay, 1922 Ountry) Director Usual Residence of Decedent ral", or items 23a or 28a-f show Ex-miner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant I fiem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg Maryland Montgomery 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 333 Russell Avenue, Suite 511 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ò Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Riker Sleeth Florence Althouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daryl E. Paunil/Son 1 Colesville Manor Court, Silver Spring, MD 20904 Baltimore, t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of H Arlington National Cemetery XX Burial 2 Cremation 3 Removal from State Mayo 19 Important: I any injury o 4 Donation 5 Other (Specify) Arlington, VA . Signature of Funeral Service Lisensee 유기에 3<sup>nd</sup> 1<sup>nd</sup> 5<sup>nd</sup> 5<sup>nd</sup> Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicianz disease or condition Abdominal Wall Hematoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER executed the burial-transit and Due to (or as a consequence of): resulting in death) Last nis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burnant of the set the burnant of the set of the P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Aspiration Pneumonia, Parkinsonism, Abdominal Aortic Aneurysm Completed 2 No 3 Probably 41 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🕏 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Division of Vital Records,

Medical only one 29b. Signature and title of certifie

1 Natural

Accident

3 Suicide
4 Homicide

(Check

5 Pending

Investigation

determined

6 Could not be

State Registrar

Nicole Christensen, CRNP 1355 Piccard Drive, #100, Rockville, MD 20850 31. Date filed Appets, Day, Year, 2010 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year)

ached

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Norse Practioners To the best of my knowledge, Just's social of the fine, date and place, and due to the cause(s) and manner as stated

2 No

R120698

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>□</sup>2010 APR.21 MARY FRANCES PHELPS 9:30A М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12195 POTOMAC VIEW ROAD NEWBURG CHARLES Social Security Number 8. Date of Birth (Month, Day, Year) 6 – 2 3 – 1 9 5 2 9. Birthplace (State or Foreign Country) MD • If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Days Months Hours 215-64-5040 57 Director Yrs Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director MD. CHARLES NEWBURG 1 🗆 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12195 POTOMAC VIEW ROAD 20664 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: 'natural", 3 Divorced 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT RELATIONS SPECIALIST UNOCAL CORP 12th Ith and Mental Hygie 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 2 should be CHARLES W. SHLAGEL ELOISE GARDINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 12195 POTOMAC VIEW RD. DENNIS P. PHELPS-SPOUSE NEWBURG, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 4-27-10 4 Donation 5 Other (Specify) ALEX., VA. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
TA DIATA MARYLAND 20646 Signature of Furieral Service Licensee M0047 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 457 Physician/ 2 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjur) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? **Director:** After this certificated in by the funeral director, pag 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

10

16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

26

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAIMOONA HATIMALI OAIYUMI Day 010 Year April 20. 5:15A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6302 Summer Crest Drive Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Days Hours Min. May 21, Year 1921 292-60-9027 88 India Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important If item 27a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Howard Columbia 1 🗆 Yes 2 🖰 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6302 Summer Crest Drive 21045 India 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or þ 1 Never Married 2 Married ☐ Yes 2 X No Saftimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify: North Indian 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Salabhai ShahMalik Fatima ShahMalik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saifuddin Qaiyumi -son 6302 Summer Crest Drive Columbia, Maryland 21045 20a. Method of Disposition

1 Disposition 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) MD National Mem. Park 4/20/2010 Laurel, Maryland 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma U.13 Maryland 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, Alzheimers disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardio Vascular Disease Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ned by the atter detached for u in the past 12 months?
1 Yes 2 No Day Month Year Other (specify) Pregnant at time of death 9 Unknown g Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Hospital မ 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

April 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shamima Abbas, M.D. 10805 Hillbrooke Lane Potomac, MD 20854 31. Date filed (Month, Pay Year) State Registrar's Signatu Registra DHMH 17 Rev 7/2009 **ORIGINAL** 

DHMH 17 Rev 1/2001

Lednum Ave

Preston

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

136

32. Registrar's Signature

But

Melinda

State Registrar 31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                |  | •                | For State C<br>State<br>Registrar   | iviaryiano                                      |                     | tificate of L                          | heaith and i<br>Death                      |  | giene<br>Reg. No. 201                | 0 12917   |  |  |  |
|----------------|--|------------------|---|---|---------------------|--|--|--|--------------------------------------|---|--|--|--|
|                | Physicia   |                  | Decedent's Name (First, Middle, Last)  James Samue  | P Paget   |                     |  | -  | 2. Date of Dea<br>Month<br>Apri        |                                      | 3. Time of Death<br>12:50a M                            |  |  |  |
|                | Medic<br>Examin  |                  | 4a. Facility Name (if not institution, give street and num  |   |                     | 4b. City, Town, o                      | eath                                       |  |                                      |   |  |  |  |
|                |  |                  | 413 Hawkesbury Lane 5. Social Security Number 6. Sex  |   |                     | S. If Under 1 Year                     | ilver Sp.                                  |  |                                      | itgomery  |  |  |  |
|                | Funeral<br>Director  |                  | 181-18-5587 1 M 2 □ F   | 7. Age (In yrs. Ia:                             | Yrs.                | Months Days                            | Hours Min.                                 | 8. Date of Birt<br>(Month, Da<br>04/07 | y 1923 Pe                            | Birthplace (State or Foreign<br>Country)<br>LNNSYLVANÍA |  |  |  |
|                | rland<br>f show<br>ed.at   | tor              | 10a. State 10b. County  | 10c. City                                       | , Town or Loc       | eation                                 | -  |  |                                      | 10d. Inside City Limits                                 |  |  |  |
|                | e Mar<br>r 28a-<br>notifie   | Jirec            | Maryland Montgomery  10e. Street and Number   |   |                     |  | lver Spr                                   | ing                                    |                                      | 1 🗆 Yes 2 🚨 No  |  |  |  |
|                | n with th  | Funeral Director | 413 Hawkesbury Lane   |   |                     | 10f. Zip Code                          | 20904                                      |  | 10g. Citizen of What                 | U.S.A.  |  |  |  |
| Š              | e filed within 72 hours after death with the Maryland<br>tal Hyglene.<br>3d other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at.   | by               | Armed Fo  | 2 □ No Nav                                      | y                   | Vas Decedent of H<br>Yes, specify Cuba | ispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)       | Black, W                             | merican Indian,<br>hite, etc.                           |  |  |  |
| 215-0036       | atural <sup>®</sup><br>cal Exa   | Completed        | 3 ☐ Widowed 4 ☐ Divorced Year or Da   |   | <u> </u>            | ent's Usual Occup                      |  |  | Specify:                             | White   |  |  |  |
| 212            | nin 72 l<br>he.<br>han "n<br>e Medi  | omp              | (Specify only highest grade completed) Elementary/Seconday (0-12) College (1  | -4 or 5+)                                       | (Give k<br>life. DC | ind of work done of NOT use retired)   | during most of worl                        | king                                   | 16b. Kind of Busine                  | ŕ   |  |  |  |
| Maryland 21    | ed with<br>Hygier<br>other t   | Be C             | 17. Father's Name (First, Middle, Last)   |   | PB                  | X Repair                               |  | ne (First Middle                       | CEP Telex Maiden Surname)            | phone Co.   |  |  |  |
| /lan           | d be fil<br>Vental<br>arked<br>atic ev   | 욘                | Harry Rag   | er  |                     |  |  |  | Donnelly                             |   |  |  |  |
| Mar.           | 12 should be<br>Ith and Ment<br>27 is marked<br>r traumatic e  |                  | 19a. Informant's Name/Relationship (Type, Print)  |   |                     |  |  |  | r, City or Town, State,              |   |  |  |  |
| ē,             | f Hea<br>item<br>other   |                  | Rita Rager - Spouse  20a. Method of Disposition   | 20b. PI   | ace of Dispos       | sition (Name of                        |  | Date                                   | Sprung, Mo<br>20c. Location - City   | ryland 20904<br>or Town, State                          |  |  |  |
| Baltimore,     | 9 <del>+</del> + e   |                  | 1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)  |   |                     | eaven Cei                              | n. 04/1                                    | 3/2010                                 | Silver Spr                           |   |  |  |  |
| Balt           | permit. Pag<br>Departmen<br>Important:<br>any injury once.   | y 10             | 21. Signature of Funeral Service License  | Nois  | 22.<br>11 11        | Name and Addre                         | ss of Facility Hu<br>Hampshire             | ines-Rin                               | aldi Funer<br>Silver Spr             | ial Home, Inc.<br>Ling, MD 20904                        |  |  |  |
| E              |  |                  | 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximation interval Better the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and interval Better the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and interval Better the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and interval Better the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and interval Better the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death are caused the death. |   |                     |  |  |  |                                      |   |  |  |  |
| 1              | Trysician/<br>Medical  | 0                | Immediate Cause (Final disease or condition resulting in death)  Bladder Cancer  Due to (or as a consequence of):   |   |                     |  |  |  |                                      |   |  |  |  |
|                | Examiner   | _                |   |   |                     |  |  |  |                                      |   |  |  |  |
| P.             | ed   | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury  | or as a conseque                                | ience of):          |  |  |  |                                      |   |  |  |  |
| ¥              | execut<br>ian and<br>irial-trau  |                  |   |   |                     |  |  |  |                                      |   |  |  |  |
| 9              | cate be<br>physici<br>the bu   | <b>dedical</b>   | d   |   |                     |  |  |  |                                      |   |  |  |  |
| χ<br>Q         | n certifi<br>ending<br>r use as  | an/M             |   | come of pregnan<br>Birth 2  Fetal               |                     | Ectopic pregnanc                       | CV   |  | 23d. Date of                         | delivery  |  |  |  |
| . Box          | the deatl<br>by the att  | Physician/N      |   | nant at time of de                              |                     | Other (specify)                        |  |  | Month                                | Day Year  |  |  |  |
| ,<br>O         | es that<br>igned b   | by               | Part II. Other significant conditions contributing to d   | eath but not resu                               | lting in the u      | nderlying cause gi                     | ven in Part I.                             |  |                                      | to the cause of death?                                  |  |  |  |
| ords           | been s   | letec            |   | -   |                     |  |  | 24a. Was                               |                                      | Probably 4 Unknown autopsy findings available           |  |  |  |
| Vital Records, | The law<br>ate has<br>page 2   | Completed        | -   |   |                     |  |  | autop<br>perfo<br>1 \(\sum \) Yes      | osy prior t                          | to completion of cause of                               |  |  |  |
| Ita            | ician:<br>Sertific<br>ector,   | Be               | 25. Was case referred to medical examiner?  |   |                     |  | ace of Death (Chec                         |  |                                      |   |  |  |  |
| > 10           | y Phys<br>er this<br>eral dir  | e: To            | 27. Manner of Death 28a. Date   |   | 28b. Time of        | t_3 DOA Oth                            | 4 ☐ Nursing H                              |  | dence 6 Other (Sp                    | pecify)   |  |  |  |
| o              | tending<br>death.<br>tor: Afte<br>the fun  | Certificate:     | 2 Accident Investigation  | th, Day, Year)                                  | injury              |  | Yes 2 No                                   |  |                                      | injury occurred   |  |  |  |
| Division of    | To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit. |                  | 4 Homicide determined 28e. Place  | of Injury - At hon<br>ng, etc. <i>(Specify)</i> | ne, farm, stre      | et, factory, office                    |  | 28f. Location (S<br>City or Tow        | Street and Number or I<br>vn, State) | Rural Route Number,                                     |  |  |  |
|                | ne Hosp<br>n 24 hou<br>ne Funei<br>pleted fil  | Medical          | 29a. Certifier (Check conly one)  1   | is of examination                               | and/or invest       | igation, in my opinio                  | on, death occurred a                       | at the time, date a                    | ind place, and due to the            | ne cause(s) and manner stated.                          |  |  |  |
|                |  | _                | 29b. Signature and title of certifier   | 11/   |                     | 29c. Licens                            | e number                                   |  | 29d. Date signed (Mo                 | nth, Day, Year)   |  |  |  |
| )              | 10+  |                  | 30. Name and address of person who completed caus   | e of death (Item                                | 23a) (Type. P       |  | D35177                                     |  | April 7,                             | 2010  |  |  |  |
|                |  |                  | John Wallmark, MD, 97   | 07 Medi   | cal Ce              |  | ve, #300,                                  | , Rockvi                               | ele, Mary                            | land 20850  |  |  |  |
|                | Stat<br>Registra   |                  | 31. Date filed (Month, Day, Year) APR 12 2010 22. R   | egistrar's Signatu                              | le Car              | del.                                   |  |  |                                      |   |  |  |  |

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|                                 |  |  | Please   | Type or Pri  |                        |                     |   |                                     |   |                | _                              | ,  |
|---------------------------------|--|--|--|--|------------------------|---------------------|---|-------------------------------------|---|----------------|--------------------------------|--|
|                                 |  | -  | For State  | State of Ma  | arylan                 |                     | artment of tificate of                  |                                     | d Mental Hy                               | _              | COLO                           | 12018  |
|                                 |  |  | Registrar  1. Decedent's Name (First, Middle, Las                              | t)   |                        |                     | incate or                               | Death                               | 2. Date of De                             | Reg. No<br>ath | 0./                            | 3. Time of Death                                   |
|                                 | Physicia<br>Medio  |  | JEFFREY ALAN   |  | SON                    |                     |   |                                     | Month<br>APRII                            | 6<br>6         | ay Year<br>2010                | 11.57P M   |
|                                 | Examin   | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death |  |  |                        |                     |   |                                     | eath                                      |                | . County of Deat               |  |
| -                               | Funeral  |  |  |  |                        |                     |   |                                     |   |                | thplace (State or Foreign      |  |
|                                 | Director   | 175-46-9838 1 April Days Hours Min. April Day, Year, 1955 Pen Usual Residence of Decedent            |  |  |                        |                     |   |                                     |   | nsylvania      |                                |  |
|                                 | filed within 72 hours after death with the Maryland tral Hygiene. So or 28a-f show other than "hatural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.   | ctor   | 10a. State 10b. County   |  | 10c. Cit               | y, Town or Lo       |   |                                     |   |                |                                | 10d. Inside City Limits                            |
|                                 | he Mar<br>or 28a   | Funeral Director   | Maryland Frede   | rick   |                        |                     | Middle<br>10f. Zip Code                 | town                                |   | 10a C          | itizen of What Co              |  |
|                                 | with t<br>s 23a<br>ust be  | eral   | 4613 Granite Dri   | .ve  |                        |                     |   | 769                                 |   |                | ted Sta                        | •  |
|                                 | death<br>r item  |  | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?<br>1 Yes 2                             | ver in U.S             | S. 13. \            | Vas Decedent of I<br>f Yes, specify Cub | Hispanic Origin?<br>an, Mexican, Pu | (Specify Yes or No-<br>uerto Rican, etc.) |                | 14. Race - Ame<br>Black, White |  |
| 21215-0036                      | s after<br>ral", o<br>Exami  | ed by  | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                         | 1 ∐ Yes 2 ⚠<br>If Yes, Give<br>Year or Dates.                              | No                     |                     | ☐ Yes 2 🔀 N                             | Specify:                            |   |                | Specify:                       | White  |
| 2-0                             | 2 hour<br>"natu<br>edical  | Completed  | 15. Decedent's E<br>(Specify only highest gra                                  |  |                        | (Give               | lent's Usual Occu<br>kind of work done  | during most of                      | workina                                   | 16b. F         | Kind of Business               | Industry   |
| 2121                            | ed within 7<br>Hygiene.<br>other than<br>ent, the M  |  | Elementary/Seconday (0-12)   | College (1-4 or 5  | i+)                    | Ìife. D             | O NOT use retired<br>Enginee:           | ,                                   | S   | Dep            | artment                        | of Energy  |
| pu                              | be filed within 72 hours after death with the Maryland ental Hygiene.<br>ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at  | o Be   | 17. Father's Name (First, Middle, Last)  | 1  | -                      |                     |   | 18. Mother's                        | Name (First, Middle,                      | Maiden         |                                |  |
| Maryland                        | d by<br>Men<br>arke  | 2  | Benjamin A. Ro   |  |                        |                     |   | L                                   | izabeth To                                |                |                                |  |
|                                 | 12 shoulath and 27 is m  |  | 19a. Informant's Name/Relationship (T)  Janet Robertson                        | / Wife   |                        |                     | ,                                       |                                     | Rural Route Numbe<br>iddletown            |                |                                | o Code)  |
| Baltimore,                      | ige 1 and 2 s<br>nt of Health a<br>t: If item 27 i   |  | 20a. Method of Disposition  1 XBurial 2 Cremation 3                            | ·  | 20b. F                 | lace of Dispo       | sition (Name of<br>natory or other pla  |                                     | Date                                      |                | ocation - City or              | Town, State  |
| tim                             | an and and and and and and and and and a   |  | 4 Donation 5 Other (Specif   | y)   |                        | eforme              | l Cemete                                | ry 4/                               | /12/2010                                  | Mi             | ddletow                        | n, Maryland  |
| Bal                             | permit. Departr Imports any inju   |  | 21. Signature of Funeral Service Licens  | Stay /   | 101                    |                     | . Name and Addr                         |                                     | Stauffer<br>Pike, Fre                     |                |                                |  |
|                                 |  |  | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure, List only o | plications that caused   | the deat               |                     |   |                                     |   |                | ick, MD                        | Approximate  |
|                                 | Physician/   |  | Immediate Cause (Final disease or condition                                    | A S  |                        | . D                 |   |                                     |   |                |                                | Interval Between<br>Onset and Death                |
|                                 | Medical Examiner   |  | resulting in death)  | Due to (or as a  | consequ                | uence of):          |   |                                     |   |                |                                |  |
|                                 |  | iner   | Sequentially list conditions, if any, leading to immediate                     | b. Due to (or as a   | a consequ              | uence of):          |   |                                     |   |                |                                |  |
|                                 | executed<br>ian and<br>urial-transit   | Examiner   | cause. Enter Underlying Cause (Disease or iinjury that initiated events        | C  |                        |                     |   |                                     |   |                |                                |  |
| _                               | be exe<br>sician a<br>burial-  | ا⊯ا  | resulting in death) Last   | Due to (or as a  | a consequ              | Jence of):          |   |                                     |   |                |                                |  |
| 376(                            | ificate<br>ig phys<br>as the   | Medi   | IE ECMAL C   | d  |                        |                     |   |                                     |   |                |                                |  |
| Box 68760                       | ath certificate be<br>attending physic<br>for use as the bu  | ian/I  | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?             |  | 2 Feta                 | aldeath 3           | Ectopic pregnar                         | ncy                                 |   |                | 23d. Date of de                |  |
| Bo                              | Physician: The law requires that the death certificate be this certificate has been signed by the attending physiciral director, page 2 should be detached for use as the but  | Physician/Medica   | 1  Yes 2 No<br>9 Unknown   | 4 Pregnant a 9 Unknown   | t time of c            | death 5 L           | Other (specify)                         |                                     |   |                | Month                          | Day Year   |
| Division of Vital Records, P.O. | es that the dea<br>signed by the a<br>l be detached f  |  | Part II. Other significant conditions of                                       | ontributing to death b   | ut not res             | ulting in the u     | nderlying cause g                       | iven in Part I.                     | 23e. Did to                               | obacco         | use contribute to              | the cause of death?                                |
| rds,                            | v requires<br>been sig<br>should b   | Completed by   |  |  |                        |                     |   |                                     |   |                |                                | robably 4 🔀 Unknown                                |
| eco                             | e law r<br>s has b<br>ge 2 sh  | mple   |  |  |                        |                     |   |                                     | 24a. Was autop                            |                | prior to death?                | topsy findings available<br>completion of cause of |
| al<br>R                         | ding Physician: The la<br>h.<br>After this certificate ha<br>funeral director, page  | Be Co  | 25. Was case referred to medical   |  |                        |                     | 26. F                                   | Place of Death (C                   |   | 2 🔀 N          | lo 1 Yes                       | s 2 🗆 No   |
| Vit                             | hysici<br>his ce<br>al direc   | 은  | TIZE TES 2 LINO  |  |                        | ER/Outpatier        | nt 3 🗆 DOA Ott                          | ner: 4 🗌 Nursin                     | ng Home 5 Resid                           | dence (        | 6 Other (Spec                  | ify)   |
| 0                               | fter   | cate:  | 27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident Investigation        | 28a. Date of injui<br>(Month, Day  | ry<br>, Yea <i>r</i> ) | 28b. Time of injury | 28c. Inju<br>wor<br>M 1 D               |                                     | 28d. Describe h                           | now inju       | ry occurred                    |  |
| isio                            | Atten<br>er deal<br>ector:<br>by the   | Certificate:   | 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined         | e 28e. Place of Inju   | iry - At ho            | me, farm, stre      |   | 163 2 10                            |   |                |                                | ral Route Number,                                  |
| Δ                               | oital or<br>urs aftural Dir<br>ral Dir   |  |  | building, etc  |                        |                     |   |                                     | City or Tov                               |                |                                |  |
|                                 | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the fune  | Medical  | (Check 2 \( \subseteq  Medical Exami   | sician: To the best of<br>ner: On the basis of ex<br>se Practioner: To the | kamination             | n and/or invest     | igation, in my opin                     | ion, death occurr                   | red at the time, date a                   | and place      | e, and due to the              | cause(s) and manner stated.                        |
|                                 | To the Comment of the |  | 29b. Signature and title/o certifier   | rle  |                        | 2                   | 29c. Licens                             | 30488                               |   |                | ate signed (Monti              |  |
|                                 | •  |  | 30. Name and address of person who c   |  |                        |                     |   | . 111                               |   | -              | 7/0                            |  |
|                                 | /2<br>Sta  | e  | James L Roe 31. Date filed (Month, Day, Year)                                  | 32. Registre   |                        | Box a               |   |                                     | own, mo                                   | ᇇ              | 104                            |  |
|                                 | Registra   |  | APR 19   |  | . 22.24                |                     | Market                                  |                                     |   |                |                                |  |
| DHM                             | MH 17 Rev 7/20   | 009  |  |  |                        |                     |   |                                     |   |                |                                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. FOR Phy State of Maryland / Department of Health and Mental Hygiene For 4/8/10 AACO HEALIH DEPT. CMH Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Ratricia A. Ronan 2. Date of Death 3. Time of Death Physician/ Month 4 0 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 2613 Evergreen Rd. Odenton . Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) an. 4, 1934 1 □ M 2 🗹 292-32-1201 Director 78 Ohio Jan. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral 21401 USA 100 Severn Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian. Examiner Armed Forces? Black, White, etc. 6 ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No "natural". Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked of
traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Kathleen Ryan Theodore Boylan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2613 Evergreen Rd. Odenton, MD 21113 Frank J. Ronan, III / Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/6/2010 Baltimore, MD Metro Crematory 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service Licensee 6512 NW Crain Hwy., 20715 Bowie, MD Part 1. Enter the disease, or emplications that caused shock, or heart failure. List only one cause on each line at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betwee Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last burialthe attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Completed by pe Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗆 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation Could not be after death Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination allows investigation, in my spanish, secand boson as a full distribution of the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) address of person who co 31. Date filed (Month, Day, Year) State APR 0 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ам James Robinson 04 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Washington Adventist Hospital Montgomery 6. Sex 1 🔀 M 2 🗆 F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Washington, DC **Funeral** (Month, Day, Year) 03/16/1935 Months Days Hours Director 577-46-6192 75 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County with the Maryland 10c. City. Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits 1X Yes 2 ☐ No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12316 Putters Court USA 20772 and Mental Hygiene. is marked other than "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Black 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) 8 Mail Sorter US Postal Service any injury or other traumatic event, once. permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Senior Nora Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Graham - Daughter 12316 Putters Court Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 4/12/2010 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Joya Nontoney Clester 3401 Bladensburg Road Brent
23a. Fart 1. Her the disease or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brentwood, MD 20722 Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Hospital 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Registrar

DHMH 17 Rev 7/2009

State

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 1 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLUD

32. Registra 's Signature

East

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0060100

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .<sup>Day</sup> 010 Physician/ APR.19 3:30P BEATRICE ANNE READER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8675 LARK COURT BEL ALTON CHARLES 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 1 🗆 M 2 🖵 F Months Hours 1 2-29-1941 216-40-8960 68 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director MD. CHARLES BEL ALTON 1 Tes 2 No 10f. Zip Code De Strock and Number 10g. Citizen of What Country? Funeral 8675 LARK COURT 20611 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes Give SpecifyWHITE "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene.
Int If item 27 is marked other than "n ry or other traumatic pures." Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည CURTIS VAN BARR ADA BEATRICE FREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JULIE SALVIEJO-DAUGHTER P.O.BOX 1254 LA PLATA, MARYLAND 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) permit. Page 1 Department of Important: If it any injury or o 1 🗌 Burial 2 🔀 Cremation 3 🗀 Removal from State METROPOLITAN CREMATORY 4-21-10ALEX., VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 Signature of Juneral Service Licens M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (o the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year cate has been signed by the page 2 should be detached

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 this certificate has funeral director, 24 hours after death Funeral Director; A completed filled in by

| 1 ∐ Yes 2 🗗 No<br>9 ☐ Unknown  | g Unknown  |   |  |  |  |
|--|--|---|--|--|--|
| Part II. Other significant conditions                                  | contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown               |  |  |  |
| •  |  | 24a. Was an autopsy performed?  1 \( \sum \) Yes 2 \( \sum \) No \( \sum \) No \( \sum \) Yes 2 \( \sum \) No |  |  |  |
| 25. Was case referred to medical                                       | 26. Place of Death (Check or   | only one)   |  |  |  |
| examiner?<br>1  Yes 2 No   | Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home   | ne 5 Residence 6 Other (Specify)  |  |  |  |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigati | (Month, Day, Year) injury work?<br>on M 1 ☐ Yes 2 ☐ No   | d. Describe how injury occurred   |  |  |  |
| 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine                       |  | f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                                 |  |  |  |
|  | nysician: To the best of my knowledge, death occured at the time, date and place, and on the basis of examination and/or investigation, in my opinion, death occurred at the |   |  |  |  |

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

PAUL PRITCHETT, MD 118 31. Date filed (Month, Day, 32. Regis State

P0068370

29d. Date signed (Month, Day, Year) 04-20-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LA GRANGE AVE LA PLATA MD

Registrar

Medical Certificate: To

only one) 29b. Signature and title

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Richard John Herbert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS- RMC Cumberland Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpie Country) MD **Funeral** 1 ☐ M 2 ☐ F Min. Month, Day Year 1940 Months Days Hours Director 216-38-2140 69 Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21502 317 Cecelia Street USA should be filed within 72 hours after death and Mental Hygiene.
is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 1959-196 3 Widowed 4 X Divorced white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Memorial Hospital <u>respiratory therapist</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Virginia (Athey) Richard Clyde S. Richard . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) MD 21502 30 Potomac Street Mary Poling Cumberland sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit, Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State **Davis Memorial Cemetery** 4/23/2010 MD Cumberland 4 Donation 5 Other (Specify) 21. Signature of Funeral Ser 22. Name and Address of Eacility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🔲 Ectopic pregnancy the Hospital or Attending Physician: The law requires that the death ò in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No Unknown 9 Unknown been signed by should be detac Part II. <mark>Other significant conditions</mark> contributing to death but n<u>ot</u> resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

29a. Certifier

only one)

29b. Signature and title of certifie

30. Name and address of person

DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print)

Regis

r's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 20b, c per fh, g902,04/26/2010dhb
Certificate of Death
Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Day 2.0 Brenda S. Simmons 2010 1316 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Hospital E1kton Ceci1 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Date of Dis... (Month, Day, Hours 1 🗆 M 2 ី F Director June 212-52-9220 60 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 160 Hollingsworth Manor 21921 United States Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Floyd Yates Lillian Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21921 Donald R. Simmons/Husband 160 Hollingsworth Manor, Elkton, MD 20a. Method of Disposition Date **24,** April <del>26,</del> 20c. Location - City or Town, State **Elkton, MD** 20b. Place of Disposition (Name of cometery, crematory or other place)
Elkton Cemetery

Company

Comp ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 West Chester. ture of Funeral Service Licensee 21. Sign 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street. .A. E1kton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Immediate Cause (Final Onset and Peath าเงอเฉเลเซ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 No Month Year Pregnant at time of death Unknown 9 Unknown eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. **Other significant condition**s contributing to death but not resulting in the u*n*derlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed hvonic 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person wh

Date filed (Month, Day, Year)

APR 2 6 201

DHMH 17 Rev 7/2009

a) (Type, Print)

ause of death (Item 2

32 Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>010</u> Physician/ Month Samue1 April Hilton 7:50P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital 01ney Montgomery Social Security Number 8. Date of Birth (Month, Day, Jan 23 9. Birthplace (State or Foreign Country) Maryland 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 ₹ M 2 □ F 214-18-8162 87 **Director** Yrs Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes X No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11006 Locust Drive 20872 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?

1 ፟ Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 0. Black, White, etc. 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: I Hygiene. other than "natural", Specify: White 3 Divorced 4 Divorced Completed WWII Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Naval Surface Weapons Elementary/Seconday (0-12) College (1-4 or 5+) Estimator/Planner Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Walker Shipley Eloise Hilton 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Shipley - Wife 11006 Locust Drive, Damascus, Maryland injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Ponetion 5 Other (Specify) Upper Seneca Baptist 4/13/2010 Germantown, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home Signature of Funeral Service Licen our 26401 Ridge Road, Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami that the death certificate be executed attending physician and for use as the burial-transil Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Year Day 1 Yes 2 L 9 Unknown 2 No been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No 1 Yes Yes 2 Z funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital c within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0.059414 ne and address of ted cause of death (Item 23a) (Type, Print)

3+IUA

Box 68760

P.O.

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

18101 Prince Philip Drive,

Olney, Maryland

20832

| 0-03005   | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. |  |  |                      |                                      |                                |  |
|---|---|--|--|----------------------|--------------------------------------|--------------------------------|--|
| David A. Sanche   |   | State of Maryland / Department   |  | l Hygiene            | 2010                                 | 12925                          |  |
| Dhuaisis  |   | 1- For State Certificate Registrar 1. Decedent's Name (First, Middle,Last)   | or Death   | 2. Date of De        | Reg. No.                             | 3. Time of Death               |  |
| Physicia<br>Medical Examir  |   | David A. Sanchez   |  | Month<br>April 17,   | Day Year                             | 0845 hrs                       |  |
|   |   | 4a. Facility Name (if not institution, give street and number) 2012 Van Buren Street   | 4b. City, Town, or Location of D<br>Hyattsville                          |                      | 4c. County of Death                  |                                |  |
| Funeral   |   | Social Security Number 6. Sex 7. Age (In yrs. last birthday)   |  | 4Hrs. 8. Date of E   | Birth(MM/DD/YYYY) 9. Bir             |                                |  |
| Director  | 9/1989 Foreign Co   | puntry) Maryland   |  |                      |                                      |                                |  |
| w any   |   | Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Lo  | cation   |                      |                                      | 10d. Inside City Limits        |  |
| Aaryland<br>28a-f show  | ğ   | Maryland Prince Georges Hyattsv  |  |                      |                                      | 1 X Yes 2 No                   |  |
| th the Maryiand<br>23a or 28a-f sho<br>notified at once.  | Director  | 10e. Street and Number   | 10f. Zip Code  |                      | 10g. Citizen of What Cou             | intry?                         |  |
| vith th   |   | 820 Thurman Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13.   | 20783 Was Decedent of Hispanic Origin?                                   | / Specify Yes or N   | U.S.A.                               | ican Indian, Black,            |  |
| death wi  | Funeral   |  | If Yes, specify Cuban, Mexican, Pu                                       |                      | White, etc.                          |                                |  |
| after o   | by F  | 3 Widowed 4 Divorced of Divorced of Dates:   | ∑ Yes 2 No specifyS∂   |                      | n specify: Wh                        | nite                           |  |
| hours<br>'natur   | E E   |  | dent's Usual Occupation (Give kind<br>g most of working life. DO NOT use |                      | 16b. Kind of Business/               | Industry                       |  |
| 36<br>hin 72<br>e.<br>than '  | Completed   |  | Cashier  |                      | Verizon Ce                           | enter                          |  |
| 5-00<br>led wit<br>fygien<br>other  | 5   | 17. Father's Name (First, Middle, Last)  |  |                      | , Maiden Surname)                    |                                |  |
| D 21215-0036<br>should be filed within 72 hours after death with the Maryland<br>and Mental Hygiene.<br>7 is marked other than "natural", or items 23a or 28a-f she<br>natic event, the Medical Examiner must be notified at once   | 8   | David Alfredo Sanchez  | Delis  |                      |                                      |                                |  |
|   | ٩   |  | iling Address (Street and Number<br>O Thurman Ave. H                     |                      |                                      |                                |  |
| ore, Mes 1 and 2 of Health If item 2  |   |  | position (Name of cemetery, rother place)                                | Date                 | 20c. Location - City or              | Town, State                    |  |
| imore<br>Pages 1<br>nent of H<br>ant: If it   | Ш   | X Durial 2     Gremation 3     Itemoval nom State  |  | /24/2010             | Silver Spi                           | ring, MD                       |  |
| Baltimore,<br>permit. Pages I an<br>Department of Hee<br>Important: If iter   | П   | a figure of the second   | 2. Name and Address of Facility  | Rendon/H             | ale Funeral                          | Home                           |  |
| Physician   |   | 23a. Part I. Enter the lisease, or implications that caused the death. Do not ent  | 9013 Annapolis Ferthe mode of dying, such as card                        |                      |                                      | Approximate Interval           |  |
| /Medical<br>Examiner  |   | failure. List only one codie on each line.  Immediate Cause (Final disease a. Exsanguination                                       |  |                      |                                      | Between Onset and<br>Death     |  |
| ~ !   |   | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions  b. Cocaine-assicated             | ischomic proctit   | ie                   |                                      |                                |  |
|   | 힏   | if any, leading to immediate Due to (or as a consequence of):  | ischemic procert   | .15                  |                                      | 2                              |  |
|   | Examine   | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) I ast  Due to (or as a consequence of): |  |                      |                                      | -                              |  |
| ecuted<br>and<br>transit  | al<br>Ex  | d  |  |                      |                                      |                                |  |
| 760, icate be exe   |   | X UNPENDED PT line a-b, 27,28  | a-f,per ME g904  | 6/14/10              | TT                                   |                                |  |
| 68760, certificate be nding physici use as the buri   | Physician/Medic   | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live high   | Fetal death 3 Ectopic pr   |                      | 23d. Date of deliver                 | y<br>Day Year                  |  |
| ox 687 cath certifi   | icia  | past 12 months?  | Other (Specify)  |                      | 1                                    |                                |  |
| BOX.  the death c y the atten y the atten   | Phys  | 1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the               | na undachina causa diyan in Part I                                       | 23e Did              | tobacco use contribute to            | the cause of death?            |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Š   | Tark it. Other significant conditions continuing to death but not resulting in a   | le underlying cause given in Fait i.                                     |                      | es 2 ✓ No 3 Pro                      |                                |  |
| ords,   | etec  |  |  | 24a. Wa              |                                      | utopsy findings available      |  |
| Recol The law   | Completed   |  |  |                      | formed? death?                       | completion of cause of es 2 No |  |
| tal Recian: The   |   | 25. Was case referred to medical   | 26.Place of Death (Ch  |                      | 2 10                                 |                                |  |
| Vital Physician:<br>this certifi  | To Be   | examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati   |  | ursing Home 5        | Residence 6 🗸 Othe                   | r: Scene                       |  |
| ding Ph. After t  |   | 27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time  | of Injury 28c. Injury at Work?   | Vascul               | e how injury occurred<br>ar ischemia | following                      |  |
| Sior<br>Attend<br>r death<br>ector:<br>by the   | cati  | 2 X Accident Investigation Fd 4/17/10 Fd 8:  | Z/am   | cocain               | e use<br>(Street and Number or Ri    | ural Poute Number City         |  |
| Divisi<br>pital or At<br>ours after d<br>teral Direct<br>filled in by   | Certification:  | 3 Suicide 6 Could not be determined (Specify) found in re  |  | or Town,             | State) 2012 Van                      | Buren St                       |  |
| Divis Hospital or A 24 hours after Funeral Dire   | S S   | 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death or   | curred at the time, date and place,                                      |                      |                                      | ted.                           |  |
| To the Howithin 24 h  | edical  | one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.  |  | red at the time, dat |                                      |                                |  |
|   | Σ   | 29b. Signature and title of certifier  | 29c. License number O.C.M.E.   |                      | 29d. Date signed (Mo                 | ontn, Day, Year)               |  |
|   |   | 30. Name and address of person who completed cause of death (Item 23a)   | U.U.IVI.E.   |                      | April 10, 2010                       |                                |  |
| 21  |   |  | n Street, Baltimore, MD 2  | 1201                 |                                      |                                |  |
| Sta<br>Regist   | ate   | 31. Date filed (Month, Day, Year) 32. Registrar's Signature 3. APR 2 1 2010 Service 3. April 2010                                  | /  |                      |                                      |                                |  |
| Negist  | للند  | ni ii a - Lori   |  |                      |                                      |                                |  |

DHMH 17 Rev 1/2001 OCME 2006

OGME

## State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Robert Edward Thompson April 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death Examiner College View Center Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 □ F 73 227-48-9596 Director Mar 14, 1937 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Itm M-dical Exprint Trust be notified at once. 10a State 10h Counts 10c. City. Town or Location Funeral Director Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16632 Toms Creek Church Road 21727 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 INo Specify: ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Marie Thompson Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Pyles, companion 16632 Toms Creek Church Road, Emmitsburg, MD 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State Trinity Lutheran Cem 4/12/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nd stage & **Physician** End /Medical Examiner ravdiamyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as e consequence of) Physician/Medical

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

9 Unknown

4 ☐ Pregnant at time of death

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Certification: To

ģ

Completed

Be

Medical

IF FEMALE

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

| Part II. Other significant condit                             | ions con             | ntributing to death but not resu                            | Iting in the underl                 | ying caus            | se given in                   | Part I.                          |              | 23e. Did tobacco us                          |       | ntribute to the cau<br>3□ Probably   |                                     |
|---|----------------------|---|-------------------------------------|----------------------|-------------------------------|----------------------------------|--------------|--|-------|--|-------------------------------------|
|   |                      |   |                                     |                      |                               |                                  |              | 24a. Was an autopsy performed?               |       | . Were autopsy fi<br>prior to completi<br>death?<br>1 \( \text{Yes} \) 2 \( \text{II} \) | ndings available<br>ion of cause of |
| 25. Was case referred to medical examiner?                    | al                   |   |                                     |                      | 26                            | Place of Deal                    | h (Ci        | heck only one)                               |       |  |                                     |
| 1 Yes 2 No  | Н                    | lospital: 1 ☐ Inpatient 2 ☐ I                               | ER/Outpatient 3                     | □ DOA                | Other:                        | Nursing H                        | ome          | 5 ☐ Residence 6                              | Ot    | ther (Specify)   |                                     |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi 2 ☐ Accident invest | ng<br>igation        | 28a. Date of Injury<br>(Month, Day, Year)                   | 28b. Time of<br>Injury              | 28c.                 | Injury at<br>Work?<br>1 ☐ Yes | _                                |              | Describe how injury                          |       |  |                                     |
| 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ                  | not be<br>mined      | 28e. Place of Injury - At ho<br>building, etc. (Specify     |                                     | factory, of          | ffice                         |                                  | 28f.         | Location (Street and<br>City or Town, State) | d Num | ber or Rural Rou   | te Number,                          |
| 29a. Certifier 1 Lertify (Check only one) 2 Medica            | ing Phys<br>I Examir | sician: To the best of my knowner: On the basis of examinat | vledge, death occion and/or investi | curred at gation, in | the time, o                   | date and place<br>on, death occu | and<br>red a | due to the cause(s)<br>at the time, date and | and n | manner as stated   | cause(s)                            |

3 Ectopic pregnancy

5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

51

State

Registrar

31. Date filed (Month, Day, Year)

Hemen

29b. Signature and title of certifier

shah

Thomas -0 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D60417

29c. License number

Dr Frederick

5:00 a

Birthplace (State or Foreign Country)

10d Inside City Limits

Approximate Interval Between Onset end Death

1 ☐ Yes 2 X No

4c. County of Death

USA

Trucking

Taneytown, MD

23d. Date of delivery

29d. Date signed (Month, Day, Year)

-8-2010

Month

Day

Year

14. Race - American Indian.

Specify: Black

Frederick

Virginia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P M Robert Howard Willev 3:20 2010 Medical 4a. Facility Name (if not institution, give street and humber, Examiner 4b. City, Town, or Location of Death 4c. County of Death 3001 7. Age (In yrs. last birthday) If Unde 9. Birthplace (State or Foreign If Under 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Hours Jan. 3, 213-60-8810 Mary land Director 59 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10d. Inside City Limits MDDorchester Cambridge 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5308 Second Street 21613 USA Was Decedent Armed Forces?

1 Yes 2 No 70-71 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry pe 1 and 2 should be filed within 72 tof Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired)
truck driver Elementary/Seconday (0-12) College (1-4 or 5+) seafood Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Robert Edgar Willey Cecelia Mary Tobat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ann Willey wife 5308 Second St., Cambridge, MD 21613 Department of Healti Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemi 4/12/10 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mhosis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the offending the control of the Funeral Director. attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion death? performed? Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation M 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D-156 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

VAMHCS

MD

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

| Ī                        | Physici   |                   | 1. Decedent's Name (First, Middle, Last)  Mary Jane Welty   |   | 2. Date of Dea<br>Month<br>April           | Day Year                                     | 3. Time of Death 2:15 A M   |  |
|--------------------------|---|-------------------|---|---|--|--|---|--|
| 1                        | /Medic<br>Examin  |                   | 4a. Facility Name (If not institution, give street and number) 626 North Houcksville Road   | 4b. City, Town, or Location of Death Hampstead  |  | 4c. County of Death Carroll County           |   |  |
|                          | Funeral<br>Director   |                   | 5. Social Security Number 215–36–9580 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) 70 Yrs.   | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.                                       | 8. Date of Birth<br>(Month, Day<br>May 26, | <sup>9. Bi</sup><br>1939 Per                 | rthplace (State or Foreign<br>Country)<br>Insylvania                |  |
|                          | e Maryland<br>a-f show  | ctor              | 10a. State 10b. County 10c. City, Town or Lo Maryland Carroll County Hampstead  | d<br>   |  |  | 10d. Inside City Limits 1 ☐ Yes 2 No                                |  |
|                          | th with the 23a or 2 ast benue  | Funeral Director  | 10e. Street and Number<br>626 North Houcksville Road  | 10f. Zip Code<br>21074  |  | log. Citizen of What C<br>Inited Stat        |   |  |
| 9036                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be notified at once. | ठ्                | 1 Never Married 2X Married 1 TYes 2X No   | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto<br>1 □ Yes 2 No Specify: | pecify Yes or No-<br>Rican, etc.)          | 14. Race - Am<br>Black, Wh<br>Specify: W     | te, etc.  |  |
| 21215-0036               | d within 72 ho<br>giene.<br>er than "natu<br>er the "nodical"   | Completed         | (Specify only highest grade completed) (Give  | edent's Usual Occupation be kind of work done during most of work DO NOT use retired) clerk             | ·  | manufactu                                    |   |  |
| /land                    | uld be file<br>Mental Hy<br>arked other   | To Be (           | 17. Father's Name (First, Middle, Last) Isaac Byers   | 18. Mother's Name<br>F.dith Dec   |  | Maiden Surname)                              |   |  |
| Baltimore, Maryland      | and 2 sho<br>lealth and<br>m 27 is mo   | ·                 | Charles E. Welty - husband 626 M  | ing Address (Street and Number or Rur<br>North Houcksville )  | Road H                                     | lampstead,                                   | MD 21074  |  |
| timore                   | t. Pages 1<br>rtment of P<br>rtant: If ite  |                   | 4 Donation 5 Dotner (Specify) Union Ce  | emetery   | il 12 <b>,</b><br>2010                     | 20c. Location - City of Keymar, Ma           | ,   |  |
| Bal                      | permi<br>Depar<br>Impor<br>any ir   |                   |   | 2. Name and Address of Facility E.J.<br>34 South Main Stre  |  | eral Home<br>pstead, Ma                      | ryland 2107   |  |
|                          | eath certificate be executed  attending physician and for use as the burial-transit  attending physician and for use as the burial-transit  | dical Examiner    | 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): | nter the mode of dying, such as cardiac  ISCHEMIA  CLUNG CA   |  |  | Approximate Interval Between Onset and Death HOULES                 |  |
| P.O. Box (               |   | Physician/Medical |   | ☐ Ectopic pregnancy<br>☐ Other (specify)  |  | 23d. Date of d<br>Month                      | elivery<br>Day Year   |  |
| Ś                        | e law requires that the d<br>has been signed by the<br>je 2 should be detached  | þ                 | Part II. Other significant conditions contributing to death but not resulting in the u  | underlying cause given in Part I.   |  |  | to the cause of death?  Probably 4 Donknown                         |  |
| Division of Vital Record | To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached completely filled in by the funeral director,     | Completed         |   |   | 24a. Was a<br>autop<br>perfor<br>1 □ Yes   | sy prior to<br>med? death?                   | autopsy findings available<br>o completion of cause of<br>es 2 □ No |  |
| f Vit                    | hysicial<br>his certi<br>I directo  | To Be             | 25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie  | 26. Place of Deat   |  | ne)<br>lence 6 ☐ Other (S <sub>l</sub>       | pecify)   |  |
| sion o                   | To the Hospital or Attending Physician: The Within 24 butus after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page  | Certification:    | 27. Manner of Death  1 Matural 5 Pending investigation  2 Accident 6 Could not be 288. Place of Injury. At home form at   | Work?<br>M 1 □Yes 2 □No   |  | ow injury occurred                           |   |  |
| <u> </u>                 | ital or Al<br>irs after or<br>ral Direc<br>led in by  | Certifi           | determined determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)   | reet, factory, office   | 28f. Location (S<br>City or Tow            | Rireet and Number or I<br>In, State)         | Rural Route Number,   |  |
|                          | To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the  | Medical           | 29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, dea  2 ★ Medical Examiner: On the basis of examination and/or in and manner stated.  | th occurred at the time, date and place, nvestigation, in my opinion, death occur                       | , and due to the rred at the time, o       | cause(s) and manner<br>date and place, and d | as stated.<br>ue to the cause(s)                                    |  |
|                          | MIL   | Σ                 | 29b. Signature and title of certifier  A. Z. Heek   | 29c. License number  5 44164  |  | 29d. Date signed ( <i>Mo.</i>                | 17.   |  |
|                          | 4   |                   | 30. Name and address of person who completed cause of death (Item 23a) (Type, A, Z, HEGAZI, M, D, HGB THO)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |   | VE FRE                                     | SERICK, I                                    | MS 21702  |  |
|                          | Sta<br>Registr  | ar                | APR 1 2 2010 Kenun S.   | pare  |  |  |   |  |
| DHI                      | MH 17 Rev 1/2   | 001               |   | •   |  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.2 ()

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 2010 ARTHUR JAMES WORNS 5:25 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HOSPICE OF QUEEN ANNE'S HOSPICE CENTER CENTREVILLE QUEEN ANNE'S 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 Months Days Hours Min. Director 76 NOVEMBER 19 NEW YORK 119-26-0889 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🗶 No **MARYLAND** QUEEN ANNE'S GRASONVILLE 10e. Street and Number Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be I 10f. Zip Code 10g. Citizen of What Country? with Funeral **404 NARROWS POINTE DRIVE** 21638 UNITED STATES be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status as Decedenting of the Property of the Control of th 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. Specify: WHITE 3 Divorced 4 Divorced Completed WAR 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) FINANCIAL Elementary/Seconday (0-12) College (1-4 or 5+) 12 REGIONAL MANAGER SERVICES other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked 2 permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. PERCY WORNS LAURA LARTIGUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA WORNS/WIFE 404 NARROWS POINTE DRIVE, GRASONVILLE, MD 21638 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State APRIL 4 ☐ Donation 5 ☐ Other (Specify) 2010 STEVENSVILLE, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ - MOTA STATIL namy disease or condition CANLER **Medical** resulting in death) Due to fr as a consequence of): **Examiner** MITH STASE 7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit certificate be executed and Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 as attending IF FFMALE esn 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Year Yes 2 No 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed certificate | 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions. 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation M 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined Medical 29a. Certifier 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JEFFRE 31. Date filed (Month, Day, Year)

e and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Busch

State Registrar 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

### State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL C. KENNEDY WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death QUEENSTOWN QUEEN ANNE'S 7400 MAIN STREET 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ▼M 2 □ F Hours Min DECEMBER 31,1934 Director 159-28-7776 75 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MARYLAND QUEEN ANNE'S QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7400 MAIN STREET 21658 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1953–1956 1 Yes 2 X No Specify. 3 🗙 Widowed 4 🗆 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 ENGRAVER/DIE MAKER **ENGRAVING** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment, Important: If item 27 is marked any injury or other transment. 2 H. LE BARRÉ WILLIAMS, JR MARISSTELLA KENNEDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JILL A. REBSAMEN/COMPANION 309 FOX RUN, GRASONVILLE, MARYLAND 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State APRIL 6 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 2010 21. Signature of Fune al Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a cardine. Immediate Cause (Final Physician/ disease or condition resulting in death) non Smal Medical Due to (or as a consequence of): Examiner Sequentially list nonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the death certificate be executed oronary physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 Yes 2 No Pregnant at time of death signed by the a detached for 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, Completed 24a. Was an has e 2 autopsy performed' certificate Yes 2 🗆 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 JH6 Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 ☐ Natural 2 ☐ Accident 5 Pendina s after death. Il Director: Aft ed in by the fur 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral D completed filled i Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1⁴ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The desired in the de

2010

4:30 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 No

PENNSYLVANIA

State

29a. Certifier

29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ 0626N Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13403 Vandiver Court Upper Marlboro 8. Date of Birth
(Month, Day, Year)
28,1943 Prince George's . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 M 2 F Months Days Hours Min. Director 217-42-1696 66 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Upper Marlboro Prince George's 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13403 Vandiver Court 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Divorced 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cataloquer Library of Congress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Barnes Edward Olive Dunnington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie F. Whitaker/Spouse 13403 Vandiver Court, Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemi. 4/13/2010 Cheltenham, Maryland 21. Signatur Frieral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Processor Start Contraction of the Contraction of t Immediate Cause (Final CETUM Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2. No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in a stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29c. License number and address of perso ted cause, of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year LAWRENCE WOODROW WILSON SR. 4/8/2010 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GROEGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours Month, Pay, Year 7/9/1932 Director Gibsland,LA 434-42- 1179 77 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No DC Washington 10e. Street and Number 6 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1227 46th Street SE 20019 United States or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates. 1 ☐ Yes 2🛣 No Specify. Specify: Black Completed 3 1 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Military Government permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelius Wilson Hattie V. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Gray / Grand Daughter 46th Street SE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 6/8/2010 Arlington, VA Arlington 21. Signature of Funeral Service Licensi 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) TATAL Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence or) flany, leading to immedicause. Enter Underlying Cause (Disease or iinjury -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þλ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation

Division of Vital within 24 hours after death.

To the Funeral Director: Aff completed filled in by the fur

Medical

Signature and title of certifie

4 Homicide

29a. Certifier

(Check

completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

State Registrar Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28f. Location (Street and Number or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gary Wyatt 2025 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death pato Social Security Numb 7. Age (In yrs. last birthday, ff Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) 1 🔯 💥 2 🗆 F Months Davs Hours Min. (Month, Day, Year Director 217-60-4553 MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Odenton 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 649 Chapelgate Drive 21113 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 🕏 Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2XXIIo Specify: "natural", If Yes, Give Completed 3 Widowed 4XXDivorced Specify: white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Newspaper deliveryman Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Ε. Wyatt Naomi Sizemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl E. Wyatt- father 2131 Whiteford Rd., Whiteford, MD 21160 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Kurial 2 Cremation 3 Removal from State Union Chapel Cem. 4 Donation 5 Other (Specify) 4/21/10 Delta,PA 21. Signature of Juneral ervice Acens 22. Name and Address of Facility Harkins F.H.Inc., 600 Main St.Delta, 11 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final Onset and Death Phy<del>sicia</del>n, disease or condition Du to (or as a consequence of) Medical resulting in death) <sup>'</sup>Examiner Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and -fransit Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical or Attending Physician; The law requires that the death certificate be P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown the detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 1 🗆 Yes 2 🗆 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 
Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 🗆 No Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie completed (Check

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

DHMH 17 Rev 7/2009

DA

within 2

eled cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

DAYID SONVITE, mg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 28d-f per ME g903 5/19/10 TT

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chu Jung Yang 2010 Medical 8:41 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Tiawan 1 □ M 2X F Hours 2/10/1927 Director 218-90-1741 83 Yrs. Usual Residence of Decedent Show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 10273 Tuscany Rd. 21042 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Maryland 21215-0036 þ 1 Never Married 2 Married If Yes, Give Year or Dates 3 Widowed 4 □ Divorced 1 ☐ Yes 2 X No Specify Asian Completed ed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier 7 is marked other t 8 Homemaker Own Home it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygi rtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hsin Yun Hsieh Simei Liao 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10273 Tuscany Rd. Ellicott City, MD 21042 Mei Chi Yang - Daughter Baltimore, 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 12/2010 Ardent Cremation 4 Donation 5 Other (Specify) Hanover, MD of Funer Service Li 22. Name and Address of Facility Harry H. Witzke's Family F.H. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph sician/ Aspiration Pneumonia Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical 0 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? The law requires that the death Month Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? End Stage Renal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No certificate Left Hip Fracture 2 No the Hospital or Attending Physician; 25. Was case referred to medical a 26. Place of Death (Check only one) examiner? n 24 hours after deaun. h**e Funeral Director:** After this ce noleted filled in by the funeral dire Hospital 1 M Inpatient 2 ER/Outpatient 3 DOA ျဉ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d Describe how injuly pocurred of car Natural Accident 5 Pending Certifical 4/7/2010 8:00 AM 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, 22/15 TO Signature 100 Parking Lo 28f. Location (Street and Number of Rural Boute Number, City or Town, State) 2245 Rolling Run Dr Woodlawn, MD office 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Octiving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D0053337 April 10, 2010 30. Name and address of person who completed caus death (Item 23a) (Type, Print) 2835 Smith Avenue Ste. 203 Baltimore, MD 21209 Dorothy Seay MD 31. Date filed (Month State 32. Registrar's Signature Registrar

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|  |                     | For<br>State<br>Registrar   | State of N   |  | d / Depa   | artment of I<br>tificate of L               | lealth and   | •                                       |   |                                   | 12035  |  |
|--|---------------------|---|--|--|--|---|--|---|---|-----------------------------------|--|--|
| Physicia<br>Medic<br>Examin  | cal                 | Decedent's Name (First, Midel Alexander 2     Alexander 4a. Facility Name (if not institution)  | Zades  | 4b. City, Town, o  | Location of De   | 2. Date of De<br>Month<br>April             | 6,   |   | 3. Time of Death<br>8:00 A <sup>M</sup> |                                   |  |  |
| Funeral<br>Director  | iei                 | Frederick Vil<br>5. Social Security Number<br>279-10-1560   | hab<br>st birthday)<br>Yrs.                                | Catonsville Balti  Jif Under 1 Year Jif Under 24 Hrs. 8. Date of Birth |  |   |  | Baltimor 9. Birt                        |   |                                   |  |  |
| Maryland 28a-f show notified at  | irector             | Usual Residence of Decedent   | •  |  | , Town or Loc  | ille  |  |   | 1910                                    | ) [wes                            | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No         |  |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.          | by Funeral Director | 10e. Street and Number  907 Fordwood (  11. Marital Status  1 □ Never Married 2XXM  | 12. Was Decedent Armed Forces 1 Yes 2 X                    | ?  | 1  | Vas Decedent of H                           | n, Mexican, Pue  | Specify Yes or No-<br>erto Rican, etc.) |   | USA  14. Race - Amer Black, White | nican Indian,<br>e, etc.                       |  |
| vithin 72 hours a<br>jene.<br>er than "natural'<br>the Medical Ex  | Completed           | 3 Widowed 4 Divorce  15. Decer (Specify only hig  Elementary/Seconday (0-12)  | 16a. Deced<br>(Give I<br>life. De                          | lent's Usual Occup<br>kind of work done of<br>NOT use retired)         | ation  | 16b. K                                      | Specify: White  Kind of Business Industry  astern Products |   |   |                                   |  |  |
| uld be filed v<br>I Mental Hyg<br>narked othe<br>natic event,  | To Be               | 17. Father's Name (First, Middle<br>Anastasios  | Zades  |  |  |   |  | ame (First, Middle,<br>aramihal         |   |                                   | oduces   |  |
| 1 and 2 sho<br>of Health and<br>item 27 is r<br>other traun  |                     | 19a. Informant's Name/Relationship (Type, Print)  Mary C. Coutros / daughter  20a. Method of Disposition  19b. Mailing Address (Street and Number or Fig. 1)  631 Weller Dr., Mt.   |  |  |  |   |  |   |   |                                   |  |  |
| ermit. Page<br>lepartment of<br>mportant: If<br>ny injury or<br>nce.   |                     | 1   |  |  | ek Ort   | hadox Cer<br>hodox Cer<br>. Name and Addres | n. 4/9   | 9/2010<br>Beall Fu                      |   | dlawn, 1                          | MD   |  |
| Physician/<br>Medical<br>Examiner  |                     | 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death cycling in death)   |  |  |  |   |  |   |   |                                   |  |  |
| executed<br>an and<br>rial-transit   | cal Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  |  |  |  |   |  |   |   |                                   |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but | Physician/Medic     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   No serior   Yes 2   No   Yes   Yes   No   Yes  |  |  |   |  |   | 23d. Date of delivery<br>Month Day Year |                                   |  |  |
| quires that then the sen signed by build be detac  |                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use con  |  |  |  |   |  |   |   |                                   | the cause of death?                            |  |
| n: The law re<br>ficate has be<br>or, page 2 sh  | Completed by        | 25. Was case referred to medic;   | ol T   |  |  |   |  | 1 L Yes                                 | osy<br>ormed?                           | prior to death?                   | opsy findings available completion of cause of |  |
| nding Physicia<br>ath.<br>r: After this certi<br>ie funeral direct   | icate: To Be        | examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Penc 2  Accident Inves   | Hospital:<br>1 ☐ Inpa<br>28a. Date of inj                  | ER/Outpatien<br>28b. Time of<br>injury                                 | 26. Place of Death (Check only one)  1 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at work?  M 1 Yes 2 No |   |  |   |   | fy)                               |  |  |
| spital or Atte<br>ours after de<br>eral Directo<br>filled in by th   | cal Certificate:    | 29a. Certifier   1   Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) a  |  |  |  |   |  |   |   |                                   |  |  |
| To the Hos within 24 h To the Fun completed  | Medical             | (Check 2 L Medical  | I Examiner: On the basis of<br>ng Nurse Practioner: To the | examination  | and/or invest  | igation, in my opinic                       | n, death occurre<br>time, date and p                       | d at the time date a                    | and place,<br>e cause(s                 | and due to the o                  | ause(s) and manner stated stated.              |  |
| 15   |                     | Charles K Gr  | n who completed cause of                                   | 1 Pin  | e He   | rint)<br>19 kts A                           | ve ba  | Himou                                   | M                                       | 2121                              | -9   |  |
| Stat<br>Registra   |                     | 31. Date filed (Month, Day, Year)<br>APR 082  | 010 32. Regist   | rar's Signatu  | her K  |   |  |   |   |                                   |  |  |

|                            |  |                 | Amend 20a-c, 22,   | Type or Pri  | nt in Black  | Indelible In   | k. Ensure All                                    | Copies A  | re Legible.  |   |  |
|----------------------------|--|-----------------|--|--|--|--|--|---|--|---|--|
|                            |  |                 | = State<br>Registrar   |  |  | Certificate of   | Death  | Reg.  | Reg. No.   |   |  |
| 4                          | Physici<br>/Medi   |                 | Decedent's Name (First, Middle, Las     Aa. Facility Name of not institution, give   |  | Δ  | rmstron  | Vî   | April   | Day Year 10, 2010 4c. County of Death                | 3. Time of Death                              |  |
|                            | Examir   | ner             | The Johns Hopkins Hopk | ospital  | e (In yrs. last birthe   | Baltimore  day) If Under 1 Year  Months   Days   | If Under 24 Hrs. 8                               | B. Date of Birth<br>(Month, Day, Yea<br>Jan 25, | 9. Birth   | place (State or Foreign                       |  |
|                            | Director   |                 | 219-38-3854  |  | 10c. City, Town o  |  |  | Jan 22, .                                       |  | 10d. Inside City Limits                       |  |
|                            | Maryla<br>a-f sho<br>ied at  | tor             | MD 100. County   |  |  | ltimore  |  |   |  | †X Yes 2 □ No                                 |  |
| 036                        | with the<br>a or 28<br>be noti   | Director        | 10e. Street and Number   |  |  | 10f. Zip-Code  | 21221  | 10g.  | Citizen of What Cour                                 | •   |  |
|                            | I be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | d by Funeral    | 2024 Fountain St  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: |  | 21231  S.   13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 🐒 No Specify: |  |   | 1  | can Indian,<br>etc.<br>1 <b>ite</b>           |  |
| 21215-0036                 | in 72 h<br>n "natu<br>fedical  | Completed       | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   | de completed)  | (Give kind of work done during most of working                         |  |  |   | 16b. Kind of Business/Industry                       |   |  |
| d 212                      | filed within Hygiene.  |                 | 12  17. Father's Name (First, Middle, Last)  | 12   |  |  | andler   | First, Middle, Maid                             | post offi  | ce  |  |
| /lan                       | should be and Mental B<br>s marked o<br>umatic ever  | To Be           | Harry Armstrong Mary Hoils   |  |  |  |  |   | and  |   |  |
| Maryland                   | d 2 sho<br>th and<br>ty is ma<br>trauma  |                 | 19a. Informant's Name/Relationship (7) Andrew Armstrong  | *.   |  |  | t and Number or Rural<br>nue West Se             |   |  | Code)   |  |
| ore,                       | Pages 1 and 2 should<br>nent of Health and Mer<br>art: If item 27 is mark<br>ary or other traumatic  |                 | 20a. Method of Disposition 1 🗆 Burial 2 🛣 Cremation 3 🗆  | Removal from State   | 20b. Place of D  | Disposition (Name of<br>crematory or other pla   | ce) Dat  | te 20c.   | . Location - City or To                              | own, State                                    |  |
| Baltimore,                 | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                 | 4 Donation A hor (Speeify<br>21. Signature of Euneral Service Licens<br>Ronald S   | in state   |  | Crematory<br>22. Name and Addr   | ess of Facility                                  |   | ltimore, M   | All and a second                              |  |
| ä                          | lm lang  |                 | 23a. Par 1. Enter the discase, a comp  | LXVIR  |  | Bradley As<br>Baltimore<br>tenter the mode of dy   | hton File<br>MD 21201<br>ing. such as cardiac or | 2134 Will<br>21222<br>respiratory arrest.       | low Spring   | Approximate                                   |  |
| The second                 | Physician  |                 | sho or heart failure. List only of<br>Immediate use (Final disease or contion resulting in death)  | ne cause on each lin   | monia  | ,  |  | ,         |  | Interval Between<br>Onset and Death           |  |
|                            | /Medical<br>Examiner   |                 |  | Due to (or as  | a consequence of   | :  |  |   |  |   |  |
|                            | red<br>nsit  | Examine         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of highry  | Due to (or as  | a consequence of   | :  |  |   |  |   |  |
| 60,                        | be executed<br>sician and<br>burial-transit  | <u></u>         | that initiated events<br>resulting in death) Last  | Due to (or as  | a consequence of   | :  |  |   |  |   |  |
| D. Box 6876                | ne death certificate buthe attending physici   | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown                           | 2 Fetal death  | 3  Ectopic pregnand 5 Other (specify)  | су   |   | 23d. Date of deliv                                   | ery<br>Day Year                               |  |
| ds, P.O.                   | w requires that the de<br>been signed by the a<br>should be detached   | by              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |   |  | the cause of death?                           |  |
| Division of Vital Records, | e la<br>has  | Completed       |  |  |  |  |  | 24a. Was an autopsy performed                   | prior to co  | opsy findings available ompletion of cause of |  |
| Vita                       |  | Be              | 25. Was case referred to medical examiner? 1 □ Yes = 2 🗙 No  | Hospital:  | - 0 □ ED/0:4=  | Oth  | 26. Place of Death (C                            |   | 0 0000000000000000000000000000000000000              |   |  |
| ion of                     | ding Phys<br>n.<br>After this<br>funeral d   | ition: To       | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injur<br>(Month, Day  | y 28b. Time of 28c. Injury at 28d. Describe how injury on              |  |  |   |  | y)  |  |
| Divis                      | al or Attences after death   | Certification:  | 3 Suicide 6 Could not be 4 Homicide determined   |  | Place of injury - At home, farm, street, factory, office 28f. Location |  |  |   | (Street and Number or Rural Route Number, wm, State) |   |  |
|                            | the Hospital hin 24 hours at the Funeral I   |                 |  |  | examination and/   |  | me, date and place, an opinion, death occurred   |   |  |   |  |
|                            | To the within 2 To the comple  | Me              | 29b. Signature and title of certifier  |  | 5  | 29c. Licens  |  | 29d.  | Date signed (Month,                                  | Day, Year)                                    |  |
|                            |  | -               | 30. Name and address of person who c   | ompleted cause of d  |  | KES  | -000   | - I Ap  | pri1 10, 2   | .010  |  |
|                            |  |                 | Ryan Felli   | ng MD  | de Cierent un  |  | 600 No   | orth Wolfe                                      | St, Baltimo  | re, MD, 21287                                 |  |
|                            | Sta<br>Registr   | I.Co            | 31. Date filed (Month, Day, Year)  ADD 2.7 201   | 32. degistra   | 's Signature   | bark   |  |   |  |   |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April Elma Bryan Albert 2010 20 7:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pickersgill Towson Baltimore 8. Date of Birth
(Month, Day, Year)
Oct. 15 1912 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2√□ F 97 454-03-6728 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 🏞 ☐ No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 USA 615 Chestnut Ave. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 👿 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: "natural", ¾☐ Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Baptist Church Financial Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Victor Bryan Lillian Peele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2937 N. Charles St., Balto., MD 21218 Shelby Lewis/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Donation 5 ☐ Other (Specify) Forest Park Lawndale 4/26/10 Houston, TX 21. Signature of Europin Service Livensee Michael J. 10 W. Padonia Rd., Timonium, MD 22. Name and Address of Facility Flagl Lemmon Funeral Home of Dulaney Valley, 23a. Part 1. Enter the disease r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or at a consequence of) Examiner Sequentially list conditions if any, leading to immediate Examine Due to (or as a consequence of): use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 LINO Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an completed filled in by the funeral director, page 2 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of pythonoxie, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title 30. Name and of death (Item 23a) ( ress of person who completed cause vpe. Print)

State Registrar Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |  |                  | 1 _ State  | partment of Health and ertificate of Death   |                                       | ene<br>g. No.2010                                 | 12938  |
|---------------------|--|------------------|--|--|---------------------------------------|---|--|
|                     |  |                  | Registrar  1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death                      | g. No.t   | 3. Time of Death                                 |
|                     | Physicia<br>Medic  |                  | Kirsten Mary Angerer   |  | APRIL                                 | Day Year 2010                                     | 02:25 AM   |
|                     | Examin   |                  | 4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location of Dear  |                                       | 4c. County of Death                               |  |
|                     |  |                  | SAINT JOSEPH MEDICAL CENTER  | TOWSON   |                                       |   | IMARE  |
|                     | Funeral  |                  | 5. Social Security Number 6. Sex 1 \( \text{ M} \) 2 \( \text{ X} \) F  7. Age (In yrs. last birthda   | Months Days Hours Min  | (Month, Day, Y                        | (ear) 9. Birth                                    | place (State or Foreign<br>ntry)<br>rida         |
|                     | Director   |                  | 220-96-0990 45 Yrs  Usual Residence of Decedent  |  | May 5, 1                              | .964   F10  | rida   |
|                     | land<br>show<br>d at   | 5                | 10a. State 10b. County 10c. City, Town or  | Location   |                                       |   | 10d. Inside City Limits                          |
|                     | Aaryla<br>8a-f<br>tified   | lect             | Maryland Baltimore Cocke   | eysville   |                                       | -   | 1 ☐ Yes 2 🛣 No                                   |
|                     | the back   | ا ق              | 10e. Street and Number   | 10f. Zip Code  | 10                                    | g. Citizen of What Cou                            | intry?   |
|                     | n with   | Funeral Director | 10604 Lakespring Way   | 21030  |                                       | USA   |  |
|                     | death<br>r item<br>ner n   |                  | Armed Forces?  | <ol><li>Was Decedent of Hispanic Origin? (S<br/>If Yes, specify Cuban, Mexican, Puer</li></ol> | pecify Yes or No-<br>to Rican, etc.)  | 14. Race - Ameri<br>Black, White,                 |  |
| 36                  | filed within 72 hours after death with the Maryland all Hygiene. do all Hygiene do all Hygiene than "tatural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at  | d by             | 1 X Never Married 2 Married 1 Yes 2 X No If Yes, Give 9 Year or Dates.   | 1 ☐ Yes 2 🛛 No Specify:  |                                       | Specify: Whi                                      |  |
| Ş                   | nours<br>natura<br>ical E  | Completed        | 15. Decedent's Education 16a, De   | cedent's Usual Occupation  | - 10                                  | 6b. Kind of Business Ir                           |  |
| 212                 | n 72 l<br>an "n<br>Medi  |                  | (Specify only highest grade completed) (Gi Elementary/Seconday (0-12) College (1-4 or 5+)  | ve kind of work done during most of wo<br>. DO NOT use retired)                                | rking                                 |   |  |
| 7                   | withii<br>giene<br><b>er th</b><br>t, the  |                  | 12 n/a   | n/a  |                                       | n/a   |  |
| p                   | filed<br>tal Hy<br>d oth   | To Be            | 17. Father's Name (First, Middle, Last)  | 18. Mother's Na  | me (First, Middle, Ma                 | aiden Surname)                                    |  |
| З                   | should be filed within 72 hours after death with the Manyland and Memtal Hygene. Is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at | -                | Richard Leo Angerer  | Mary_  |                                       | <u>retia</u>                                      | Johnson  |
| Maryland 21215-0036 | should<br>h and M<br>7 is mar<br>traumati  |                  |  | ailing Address (Street and Number or R   |                                       |   | -  |
|                     | 1 and 2 s<br>of Health<br>item 27<br>other tra   |                  | Mr. &Mrs. Richard Angerer/Parents  20a. Method of Disposition  20b. Place of Disposition   | 10604 Lakespring W   |                                       | ysville, M. Oc. Location - City or T              |  |
| nor                 | Page 1<br>nent of<br>ant: If it<br>ary or o  |                  | 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State cemetery, c  | rematory or other place)   |                                       | •   |  |
| Baltimore,          | permit. Page 1<br>Department of<br>Important: If it<br>any injury or o<br>once.  |                  | 4 □ Denation 5 □ Other (Specify) Atlanti  21. Apparing a Funeral Service   1. Wey  | 22 Name and Address of Facility  |                                       | len Burnie  |  |
| Ra                  | permit. Departr Imports any inju   | . 1              | Bryan W. Clary   | Lemmon Funeral Ho<br>10 W. Padonia Roa   | me of Dul                             | aney Valle  | y Inc.<br>93                                     |
|                     |  | П                | 23a. Part 1. Into the disease, or complications that caused the death. Do not a shock or h art failure. List only one cause on each line.  |  |                                       |   | Approximate                                      |
| 4                   | hysician   | 8 1              |  | PNEUMONIA  |                                       | 1   | Interval Between<br>Onset and Death              |
|                     | Medical  |                  | resulting in death)  a. Due to (or as a consequence of):   | 7 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  |                                       |   |  |
|                     | Examiner   | _                | Sequentially list conditions, b. 5 EPS 15  |  |                                       |   |  |
| 1                   | ejt q  | nine             | If any, leading to immediate July Due to (or as a consequence of,  |  |                                       |   |  |
| >                   | ecute<br>and<br>-trans   | xar              | Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  | 7CK  |                                       | +   |  |
| _                   | r requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit  | dical Examiner   |  |  |                                       |   |  |
| 9                   | icate<br>j phys<br>s the   |                  | d  | _  |                                       |   |  |
| 8                   | certif<br>inding<br>use a  | 2                | IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1  | Estania programa   |                                       | 23d. Date of deli                                 | /ery   |
| Pox                 | death<br>e atte  | sicia            | 1  Yes 2 No 4 Pregnant at time of death  | 5 Other (specify)  |                                       | Month   | Day Year   |
| -<br>-              | t the or<br>by the<br>stache   | Physician/Me     | 9 🗆 ONKNOWN  | - underlying source diversity Dowl   | 00 01111                              |   |  |
| J                   | ss tha<br>igned<br>be de   | by               | Part II. Other significant conditions contributing to death but not resulting in the   | e underlying cause given in Part i.  |                                       | acco use contribute to                            | bably AZ Unknown                                 |
| Records,            | equire<br>een s<br>nould   | Completed        |  |  |                                       |   |  |
| ပ္တ                 | law r<br>has b<br>ie 2 st  | mpl              |  | ,  | 24a. Was an<br>autopsy                | prior to co                                       | opsy findings available<br>ompletion of cause of |
| ř                   | i: The<br>icate<br>r, pag  |                  | OF Was are referred to medical   |  | perform<br>1 Yes 2                    | No 1 ☐ Yes  | 2 No   |
| Vital               | siciar<br>certif<br>recto  | Be c             | 25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Important 2 FR/Outpat   | 26. Place of Death (Che  |                                       |   |  |
| 0                   | g Physer this<br>eral d  | e: 10            | 27. Manper of Death 28a. Date of injury 28b. Time  | of 28c. Injury at  | Home 5 L Residen<br>28d, Describe how | ce 6 Other (Specif                                | <i>y)</i>  |
| ב                   | nding<br>ath.<br>7. Afte<br>e fune   | cat              | 1 Natural 5 Pending (Month, Day, Year) injur<br>2 Accident Investigation   | work?<br>M 1 ☐ Yes 2 ☐ No  |                                       |   |  |
| DIVISION            | er der<br>ecto<br>by th  | Certificate:     | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)  | street, factory, office  | 28f. Location (Stre<br>City or Town,  | et and Number or Rura                             | al Route Number,                                 |
| 2                   | italon<br>irsaft<br>ralDii<br>ledin  |                  | Suitaling, etc. (Speciny)  |  | Oity or rown,                         |   |  |
|                     | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the                        | Medical          | 29a. Certifier (Check ( | estigation, in my opinion, death occurred  | at the time, date and                 | place, and due to the ca                          | ause(s) and manner stated.                       |
|                     | ithin (ithin or the comple   | ž                | only one) 3 Certifying Number Practioner: To the best of my knowledge 29b. Signature and title of certifier  | e, death occurred at the time, date and p  29c. License number                                 |                                       | ause(s) and manner as s<br>d. Date signed (Month, |  |
| _                   | ⊨ ≯⊭ŏ<br>⊾   |                  | V TI   |  | 290                                   | 10nl 20   | 2010   |
|                     |  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Typ  | D 46356  | /                                     | 7   | 21204  |
|                     | /  |                  | KHOSROW TABASSI M.D.   | 1601 OSLER DR  | 1VE 700                               | WSON MY   | RYLAND   |
|                     | Stat   |                  | 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature  | barles  barles   |                                       |   | ,  |
|                     | Registra   | ar               | APR 27 2010 Serva S.   | garla  |                                       |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 22 Day Рм Physician/ 4:17 201°0° AIDUS MILTON Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Months Days 1071471924 NY 85 Director 058-18-0762 Usual Residence of Deceden 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. Director 1 Yes 2 No BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21208 USA 2 JOHN EAGER COURT Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 A Yes 2 No Black, White, etc. 1 Never Married 2 X Married ≥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done life, DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) BROKERAGE COMMUNICATIONS MANAGER permit. Page 1 and 2 should be filed Department of Health and Mental Hys, Important: If item 27 is mark—any injury or other—once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **GANCHEROW** ဂ္ CEILIA AIDUS HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 JOHN EAGER COURT, BALTIMORE, MD MYRA AIDUS/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. PARLOTINGTION (NCH 1/ZUK 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD 4/25/2010 AMUNO CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between noet in Lath Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live as a Live Pregnant at time of death Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day detached for 5 Other (specify) 1 Yes 2 L 9 Unknown **To the Funeral Director:** After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 XVo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence မ 28b. Time of 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natura 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 24 hours after deatle Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Mohth, Day, Year)

DHMH 17 Rev 7/2009

2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ruce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Seasons Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 17 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral Days Min. Hours 1 XM 2 | F Director 215-82-1763 49 Feb. 1961 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ier must be notified at Funeral Director 1 🖵 Yes 2 🗌 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3389 Dulany Street 21229 USA 12. Was Decedent Ever in U.S. Armed Forces?

↓XXYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 20 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: white Completed I "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Importantt: If item 27 is marked other than 'ampringuy or other traumatic event, the Meany injury or other traumatic event, the Meany Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Medical Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl D. Braley Kay Brenda Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Braley-wife 3389 Dulany Street, Baltimore MD 21229 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Apr.21,2010 Glen Burnie MD 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specity) Day Pregnant at time of death Yes 2 No detached 9 Unknown 9 Unknown ğ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 000 ၉ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Ratural 5 Pending injury 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

3+

State Registrar

DHMH 17 Rev 7/2009

ause of death (Item 23a) (Type, Prin

BOB

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 1 per PHYS, G902, 4/30/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy A. Broadfoot Physician/ April 26. 2**01**0 6:49 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Parkville Baltimore Oak Crest Village 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Hours Min. 1 □ M 2 💢 F Months 80 Yrs. Director 80-22-2267 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Baltimore Parkville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 8832 Walther Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary State Of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ida A. Froutz Adam L. Scheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Hettinger, Daughter 150 Rock Woods Road Oxford, PA 19363 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place Metro Crematory Inc. 04/27/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications y at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) ohysician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Récords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multi-infact Dementia, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has appleted filled in by the funeral director, page 2.3 autopsy perform 1 Yes 2 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 2 00 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct

completed filled in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Diedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, URM MSL completed cause of death (Item 23a) (Type, Print) 15 CKIJ MXW 8800 Walther Blod, Packville MO 21234 G. Harrison State Registrar

01/98/10

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Broadbox

Joro tho

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sylvia Rita Barton 2010 Year 8:30 PM April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Days Year 1931 009-18-5263 78 Vermont **Director** Usual Residence of Decedent 10b. County 28a-f shov Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Maryland 1 ☐ Yes 2 🔯 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1725 Meade Circle Road 21144 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", any injury or other traumatin. 1 ☐ Yes 2X No Specify: Completed 3 

Widowed 4 □ Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Louis Hanlon Francine Westover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kandice Barton, Daughter 1416 Georgia Avenue Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/23/10 Baltimore, Maryland Signature of Funeral Service License George MacNabb 22. Name and Address of Facility
Cremation Society (
299 Frederick Road Of Maryland, Inc. d Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENRUMONITIS ASPIRATION Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner BOWNE OBSTRUCTION SMALL Seque tially list on dilions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner SIGNOID COLON ISCHEMIA attending physician and for use as the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ▼ No
9 ☐ Unknown been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has bairector, page 2 sl autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: 

completed filled in by the f Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 . Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tit 29d. Date signed (Month, Day, Year) MA 4-23-10

State Registrar WILLIAM

BALTIMORE-WASHINGTON MADICAL CONTRACT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Betty Marie Bell 2010 6:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a Keswick Multi Care Center Baltimore 8. Date of Birth (Month, Day, Year) May 29 1931 Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 M 2 F Director 78 217-26-5625 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other traumatic event, the Medical Examiner must be notified at Director 28a-f Y☐ Yes 2 ☐ No n/a Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Completed by Funeral USA 21211 700 W. 40th St. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked Attack. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give 2x No 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County 12 Secretary n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hannah Frances Mays Joshua Talbott Kelley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Harris/friend 405 Whitaker Mill Rd., Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mays Chapel Cem. 4/24/10 Timonium, MD Signature deral Service License 22. Name and Address of Facility
emmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Inc. Michael J. 234 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. W. Approximate Interval Between Onset and Death Immediate Cause (Final neownin Ph sician/ disease or condition resulting in death) Medical Due to (or as a col Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter on denying Cause (Disease or iinjury Due to (or Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 4 Pregnant : 9 Unknown Pregnant at time of death 1 Yes 2 9 Unknown signed by to Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2: autopsy perform 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 4-Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) 29b. Signature and title of rtifie

State Registrar

Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year John Blankenshi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Butimore Hospital of City Sinai Butimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🛣 M 2 🗆 F 212-46-0388 Months Days Hours Min. July II, Year 946 63 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 □ No Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 W. 10th Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black. White, etc. 1 Never Married 2 M Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Tech BG&E Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blunkenship Charles Blankenship Anna Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Mrs Naoma Blankenship/Wife 305 W. 10th Ave<u>nue Brooklyn MD 21225</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 30, 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 MO135 23a. Part 1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Allohelie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year signed by the a 2 No Yes Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy After this certificate Yes completed filled in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural within 24 hours after death.

To the Funeral Director: At 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO April 23, 2010 DU068315 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Saltimore 01 WEI Cul, APR 27 2010 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ Lenoir 20 ได้ Helen Baker 4:45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Hours Min. Nov. 4,1916 578-03-1650 **Director** Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD 1 Yes 2 No Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 417 Twin Oaks 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even once. ٥ Mary Madgalene Miller Jacob Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Glenn Baker 417 Twin Oaks Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Batesburg Cemetery Batesburg, SC 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funer Sen de License Services PA 1 2nd Ave. SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Filysicial ARDIO - PULMONARY disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Yes 2 No 1 ☐ Yes ∠ ₹ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes Completed 24-18MA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only on Be examiner? Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After toompleted filled in by the funer. Natural 5 Pending 1 Yes 2 🔲 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge; death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name ompleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jagadish Bhandary Physician/ April 23, 2010 4:57 рΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) India Social Security Number 8. Date of Birth **Funeral** Hours 213-65-2074 1 🔀 M 2 🗆 F 8/1962" **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b, County within 72 hours after death with the Maryland Director Montgomery Village MD Montgomery 1 Yes 2xxNo 10g. Citizen of What Country? India 10e. Street and Number 20886 Completed by Funeral 8678 Delcris Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 X No Specify: Asian Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes, Give "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Bus Driver (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Narayana Bhandary Rathi Bhandary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8678 Delcris Dr. Montgomery Village, MD 20886 19a. Informant's Name/Relationship (Type, Print) Pamila D. Bhandary, wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4/25/2010 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) M01539 22. Name and Address of Facility Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licensee Mu 933 Gist Ave. Silver Spring, MD 20910 Approximate
Interval Between
Onset and Death
year 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Gastric Cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, il any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician debetached for use as the best of the best o Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this roadfform. completed filled in by the funeral director, Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) XX No 1 Inpatient 2 ER/Outpatient 3 DOA ည h Arv dary Division of V 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16 April 23, 2010 person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Ave. #1300 Chevy Chase, MD 20815 Nelson Kalil, MD; 31 Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month al Apri 16:20 P.U' 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery Examiner 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country)
Guyana 1 🗆 M 2 😾 F 56 Months Days Hours Min. (Month, Day, Year) 730-07-2243 Director Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10a. State death with the Maryland 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f slany injury or other traumatic event, the Medical Examiner must be notified a once. MD Prince George's Silver Spring 1 ☐ Yes 2 🖾 No 10f. Zip Code 10g. Citizen of What Country? Funeral 20903 1812 Greenwich Wood Drive Guyana Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 24 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Asian 3 Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roopnarine Harridat Ramrattie Dhanmun 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print)
Yashwantie H. Ramsarran, daughter 1812 Greenwich Wood Dr. Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State Better Hope Crem. Better Hope, Guyana 5/4/2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Densee 22. Name and Address of FacilitRapp Funeral & Cremation Svcs. m 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death d Trysician/ disease or condition resulting in death) PSIS Medical Due to (or s a consequence of: Examiner Sequentially list conditions, if any, leading to improve cause. Enter Underlying Cause (Disease or linjury Exami the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 🗌 No 9 Unknown the 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has autopsy performed? Yes 2 No certificate 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature an title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

eema

31. Date filed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carroll

7600

68049

Ave, Takoma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 April Physician/ 3:59 P Carolyn S. Berger 20. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Hours 64 November 28, 1945 Peru 265-76-5634 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 Yes 2 No Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15000 Plainfield Lane 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Casper Berger Margaret Benton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian C. Ott/Son 4633 Fitzpatrick Way, Norcross, Georgia 30096 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot
once, Monte on the place)
Crematorium, Inc. 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 22. Name and Address of Facility Robert A. Pumphrey Funeral RSEXVIIE; MIFYLAND W6850 Montgomery Avenue 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Pumphrey Funeral Home/ Signature of Funeral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Respiratory Failure weeks Medical resulting in death) Due to (or as a consequence of) Examiner Pulmonary Fibrosis 1 year Secure tially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Likely Mylodysplastic Syndrome, Type II diabetes Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? mellitus autopsy 1 \( \text{Yes} 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie APRIL 21, 2010 136252 cul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15V Steven Toshihiro Kariya, 10605 Concord Street, Kensington, Maryland 20895

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RAY NACHLAS BECKER Medical 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death trong N/A Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months 7/16/1923 MD 86 Director 220-12-5650 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 3305 LIGHTFOOT DRIVE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be NACHLAS ROSE **JESSE** Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALTER BECKER/HUSBAND 3305 LIGHTFOOT DRIVE, BALTIMORE, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State of BETH TFILOH CEMETERY ! 4/23/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) of Furleral Servic . Si 22. Name and Address of Facility SOL LEVINSON & BROS INC 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complication s that caused the death. Do not enter the mode arrhof dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one ca Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-transit The law requires that the death certificate be executed resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe this certificate 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 Natural 1 🗌 Yes Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                            | Physicia   | n/           | Registrar  1. Decedent's Name                                       | , ,                                     | ,  | -              |                      | tificate of                                      |                         |               | 2. Date of De                         | D:                                | av Year                                   |  | of Death       |
|----------------------------|--|--------------|---|---|--|----------------|----------------------|--|-------------------------|---------------|---------------------------------------|-----------------------------------|---|--|----------------|
|                            | Medic  | al           | Thelma Freda Cleveland  04-22-2010                                  |   |  |                |                      |  |                         |               | 10<br>c. County of De                 | 9:50                              | ) a <sup>M</sup> _                        |  |                |
| كمبر                       | Lorien Nursing Home Bel Air  |              |   |   |  |                | ir                   |  |                         |               | Harfo                                 | rd                                |   |  |                |
|                            | Funeral<br>Director  |              | 5. Social Security No.  219-16-  Usual Residence of                 | 2792                                    | ı □ M 2 🖾 E  | e (In yrs. las | st birthday)<br>Yrs. | If Under 1 Year<br>Months Days                   |                         | Min.          | 8. Date of Bir<br>(Month, Da<br>11-24 | th<br>ly, <i>Year)</i><br>4 – 1 ! | 921                                       | Birthplace (State<br>Cou <i>ntry)</i> MD | or Foreign     |
|                            | yland<br>-f show<br>ed at  | ctor         | 10a. State  | 10b. County                             | 3  |                | Town or Lo           | cation   |                         |               |                                       |                                   |   | 10d. Inside                              | -              |
|                            | ne Mar<br>or 28a<br>notifi   | Director     | MD<br>10e, Street and Num   | Harfo                                   | ca   | Bel            | Air                  | 10f. Zip Code                                    |                         | -             | Т                                     | 10a C                             | itizen of What (                          |  | es 2 🗆 No      |
|                            | with the 23a cust be   | Funeral      | 1909 Emm  |   | Road   |                |                      | 21015  |                         |               |                                       | _                                 | USA                                       | Dountry?                                 |                |
| 036                        | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   | þ            | 11. Marital Status  1 ☐ Never Marri 3 ☑ Widowed                     | ed 2  Married                           | 12. Was Decedent I<br>Armed Forces?<br>1 ☐ Yes 2 ☐<br>If Yes, Give<br>Year or Dates. |                | '                    | Vas Decedent of I<br>Yes, specify Cub            | an, Mexica              | n, Puerto Ri  | fy Yes or No-<br>can, etc.)           |                                   | 14. Race - Am<br>Black, Wh<br>Specify: Wh | ite, etc.                                |                |
| Maryland 21215-0036        | 72 hour<br>matur<br>edical   | Completed    | (Spe  | 15. Decedent's l<br>cify only highest g |  |                | (Give i              | lent's Usual Occu                                | during mos              | st of working | 7                                     | 16b. ł                            | Kind of Busines                           | s Industry                               |                |
| 212                        | within giene.  |              | Elementary/Second 12  | onday (0-12)                            | College (1-4 or 5  | i+)            |                      | ONOT use retired<br>nemaker                      | ,                       |               |                                       |                                   | Own Ho                                    | me                                       |                |
| and                        | e filed<br>tral Hy<br>ed oth<br>event  | To Be        | 17. Father's Name (F  |   |  |                |                      |  |                         |               | First, Middle,                        |                                   | Surname)                                  |  |                |
| ير                         | ould b<br>nd Mer<br>mark<br>matic  |              | Walter  19a. Informant's Na   |   |  |                | 10h Mailir           | g Address (Street                                |                         |               | Smal:                                 |                                   | r Town State                              | Zin Code <b>NIT</b>                      | 2 / 1 D        |
| ž,                         | nd 2 sh<br>ealth ar<br>m 27 is<br>ier trau   |              | Peter (   | Clevela                                 | nd - Son   |                |                      | oor Cre  |                         |               |                                       |                                   |   |  |                |
| Baltimore,                 | Page 1 ar<br>nent of Hu<br>ant: If iter<br>ıry or oth  |              |   |   | ☐ Removal from State   | cei            | metery, cren         | sition (Name of<br>natory or other pla<br>Cremat |                         | Da 4 - 24 -   |                                       |                                   | ocation - City o                          |  |                |
| Balti                      | permit. Departn Importa any inju   | 70           | 21. Signature of Fur  | eral Service Licer                      | see  | 1 1            | 22                   | Name and Addre                                   | ess of Facil            | ity Brac      | lley-                                 | Ash<br>ad                         | ton FU<br>21222                           | neral                                    | Home           |
|                            | c  |              | shock, or hear  | t failure.List only                     | nplications that caused<br>one cause on each line                                    |                | Do not ente          | r the mode of dyi                                | ng, such as             | cardiac or    | respiratory ar                        |                                   | 2,1222                                    | Approxim<br>Interval B                   | etween         |
| - I                        | Physician/<br>/ Medical  | ïï           | Immediate Cause (I<br>disease or condition<br>resulting in death)   |   | a<br>Due to (or as a   |                |                      | scular   | Di.                     | sease         |                                       |                                   |   | Offset and                               | Death          |
|                            | Examiner   | Į.           | Sequentially list cor   | nditions,                               | b. —   |                |                      |  |                         |               |                                       |                                   |   |  |                |
|                            | ted<br>d<br>insit  | Examiner     | if any, leading to im<br>cause. Enter Under<br>Cause (Disease or i  | lying<br>injury                         | Due to (or as a  | a conseque     | ence of):            |  |                         |               |                                       |                                   |   |  |                |
|                            |  |              |   |   |  |                |                      |  |                         |               |                                       |                                   |   |  |                |
|                            |  | ledical      |   |   | d  |                |                      |  |                         |               |                                       |                                   |   |  |                |
| . Box 68                   | The law requires that the death certifica<br>ate has been signed by the attending p<br>page 2 should be detached for use as t  | Physician/N  | IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 9 ☐ Unknown | nonths?                                 | 23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown                         | 2 Fetal        | death 3              | Ectopic pregnan Other (specify)                  | су                      |               |                                       |                                   | 23d. Date of d<br>Month                   | lelivery<br>Day                          | Year           |
| s, P.O.                    | requires that the de<br>been signed by the<br>should be detached   | by           | Part II. Other signifi  | cant conditions                         | contributing to death b  | ut not resul   | ting in the u        | nderlying cause g                                | iven in Part            | : l.          | 23e. Did to                           |                                   | use contribute                            |  |                |
| Division of Vital Records, | The law requate has beer page 2 shou   | Completed    |   |   |  |                |                      |  |                         |               | 24a. Was<br>autoj<br>perfo            |                                   | prior to<br>death?                        |  |                |
| <u>a</u>                   | sician: The<br>certificate<br>rector, pag  | Be C         | 25. Was case referre examiner?                                      | d to medical                            | <i></i>  |                |                      | 26. F  | lace of Dea             | ath (Check o  | 1 ∐ Yes<br>nly one)                   | 2 LT N                            | lo 1 L Y                                  | es 2 No                                  |                |
| <u> </u>                   | Physic<br>this ce<br>al dire   | မ            | 1  Yes 2  | No                                      | Hospital:  1  Inpatie  |                | R/Outpatier          | t 3 L DOA  |                         | 1             |                                       |                                   | 6 ☐ Other (Spe                            | ecify)                                   |                |
| o uc                       | nding I<br>ath.<br>r: After<br>e funer   | icate        | 1 Natural<br>2 Accident   | 5 Pending                               | (Month, Day  |                | injury               | 28c. Inju<br>wor<br>M 1 [                        | ryat<br>k?<br>]Yes 2. [ | _             | d. Describe h                         | now injui                         | ry occurred                               |  |                |
| JINISIC                    | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,  | Certificate: | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could not indetermined                | oe 28e Place of Inju   |                | ne, farm, stre       | et, factory, office                              |                         | 28            | If. Location (S<br>City or Tow        |                                   | nd Number or R                            | Pural Route Nun                          | nber,          |
|                            | ne Hospit.<br>n 24 hour<br>e Funera  | Medical      | (Check 2  | Medical Exam                            | vsician: To the best of<br>niner: On the basis of ex<br>practioner: To the           | kamination a   | and/or invest        | igation, in my opini                             | ion, death o            | ccurred at th | ne time, date a                       | and place                         | e, and due to the                         | e cause(s) and m                         | nanner stated. |
| _                          | To the vithing complete the com |              | 29b. Signature and t  |   |  |                | 5-7                  | 29c. Licens                                      | se number               |               |                                       | 29d. Da                           | ate signed (Mor                           | nth, Day, Year)                          |                |
|                            |  |              | 30 Name and addre   | es of person who                        | completed cause of de  | M · D          |                      | rint)  | 006                     | 398           |                                       | Her                               | 7125,                                     | 2010                                     |                |
|                            |  |              | Benjam  | in Lee                                  | (MD) 6   | 69             | Revol                | ution 5  | <del>}.</del>           | Havn          | ede C                                 | rac                               | il 23,                                    | 210                                      | 78             |
|                            | Stat<br>Registra   |              | 31. Date filed (Month   | n, Day, Year)<br>PR 27 26               | 32 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | r's Signatu    | re                   | aled   |                         |               |                                       |                                   | (   |  |                |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 APRIL 24 4:10 P M ALFRED LEE CAWTHORNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Belcamp 206 Bald Eagle Way Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Feb. 27 Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Hours Min. Mary Land Director 59 214-56-4633 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland 벎 10d, Inside City Limits Director or 28a-f st notified 1 Yes 2 No Belcamp Maryland Harford 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 21017 206 Bald Eagle Way should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc.

African ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates American 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Mental Hygiene. Deli Clerk Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julia (nmn) Alexander Norman Edward Cawthorne .f. Page 1 and 2 shou.
.t. Page 1 and 2 shou.
.t. of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21017 Sondra O'Neal Cawthorne Spouse 206 Bald Eagle Way, Belcamp 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or o 1 Donation 5 Other Bel Air, Maryland Air Memorial Gdn: 4-30-10 . Sign ire of McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ach line. Immediate Cause (Final Physician holung disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner S. uential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown P.O. | ģ is certificate has been signed I director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires Division of Vital Records, 1 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred or Attending 1 Natural injury 5 Pending Accident Suicide s after death Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 005798 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MD

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CRBI

BACTMOCE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen C. Cronin Manthril 2010 2:15 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore City N/A Keswick Multicare Center 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Mt. Airy, MD 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min october 24 90 Yrs 217-05-3095 Director 1919 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u>. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct Baltimore Baltimore City Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States Funeral 700 W. 40th Street #208 21211 America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 72 hours after 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Courthouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Helen Horn ပ Frank Lewis 19a. Informant's Name/Relationship (Type, Print)
Karen F. Cronin/ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 s treent of Health a tant: If item 27 i 1861 Loch Shiel Road Baltimore, Maryland 21234 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apri<sup>Date</sup> 26, permit. Page 1 Department of Important: If it any injury or o Dulaney Valley
Memorial Gardens 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Timonium, Maryland 21. Signature of Foheral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P. A. Peaceful Alternatives Funeral & Cremation Center, P. A. Peaceful Alternatives Funeral & Cremation Center, P. A. Peaceful Alternatives 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death concentia Physician disease or condition 4 cars Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Pregnant at time of death Month signed by the a 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural injury 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 24 hours after deal Funeral Director. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4-26-10 00057189 30. Name and address of p erson who completed cause of death (Item 23a) (Type, Print) Ba / those Iton fans

Registrar

State

DHMH 17 Rev 7/2009

32. Registras's Signatu

21224

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ dua. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Season's Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ፟ M 2 □ F Days Hours Sept. 21 90 Director 207-07-0244 Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland be notified Maryland Baltimore Windsor Mill ā ò 10e. Street and Numbe 10f. Zip Code items 23a Funeral must 2920 Salem Road 21244 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status event, the Medical Examiner Armed Forces Il Hygiene. other than "natural", or i þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Completed 1941-45 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Be 17. Father's Name (First, Middle, Last) th and Mental F. 7 is mark မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Joseph Cieslowski 19a. Informant's Name/Relationship (Type, Print) Carol Kopp Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4√E\Donation 5 ☐ Other (Specify) Lakeview Mem. Park 4/26/2010 21. A nature of Funeral Service Licen Home of dmondson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

yes, outcome of pregnancy
Live Birth 2 Fetal death

Pregnant at time of death

Unknown

28a. Date of injury

building, etc. (Specify)

Hospital

who completed cause

10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business Industry Self Employed 18. Mother's Name (First, Middle, Maiden Surname) Anna Federovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Salem Road; Windsor Mill, MD 21244 20c. Location - City or Town, State Sykesville, Maryland Name and Address of Facility Sterling Ashton Schwab Witzke Catonsville, Approximate Interval Between Onset and Death 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Day Month Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 ☐ Yes 2 █ No 1 Yes 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at 28d. Describe how injury occurred 1 🗌 Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗌 Yes 2 🔀 No

Pennsylvania

4c. County of Death

,1919

Baltimore

**Examiner** 

Examine

Physician/Medical

þ

Completed

Be

ပ္

Certificate:

Medical

Sequentially list conditions

if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury

23b. Was decedent pregnant

Unknown

in the past 12 months?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

5 Pending

of person

Investigation

Could not be

determined

examiner?

1 🗌 Yes

27. Manner of Death

Natural Accident

3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title

and address

31. Date filed (Month, Day, Year)

29a. Certifier

30. Name

that initiated events resulting in death) Last

IF FEMALE:

and -transit Hospital or Attending Physician: The law requires that the death certificate be executed ng physician ai as the burial-t use detached has

Box 68760

Records, P.O.

Division of Vital

State Registrar

within 24 hours after death

To the Funeral Director: /

28b. Time of

Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28e. Place of Injury - At home, farm, street, factory, office

of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death <u>Reg.</u> No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Harry R. Cook 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours June 16, , 1931 Bartimore, MD 212-28-4812 78 Director Usual Residence of Decedent show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 515 Sussex 21286 Road U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or Completed by 1 Never Married 2 Married filed within 72 hours after Yes 2XXNo 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 4:05 (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) Maryland Workshop College (1-4 or 5+) Vending Manager for the Blind Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Mental tem 27 is marked o 2010 ၉ should be Samuel B. Cook Ruth Packham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Patrick Cook/ son 1702 Wildwood Drive Fallston, MD 21047 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ŏ ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) APRIL. Parkwood Cemetery 04/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Towson, MD 21204 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ruck Towson Funeral Home, Inc. 1050 York Road Immediate Cause (Final Physician/ disease or condition resulting in death) a CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? 1 Yes 2 No Pregnant at time of death Month Yes the 1 Yes 2 L 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause of death? 2**X** No 1 Yes 2 No Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: |은 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE After this 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident work 1 🗌 Yes 2 🗌 No Investigation after death Director: / in 24 hour. the Funeral Directory filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

3. Time of Death

1 Yes 2XXNo

Interval Between Onset and Death

Dav

26

TIMONIUM, MD 21093

2010

Year

РМ

4:05

State Registrar

5

2300 DULANEY VALLEY RD.

32. Registr r's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy Agnes Cremen 4:08 April 22 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Greater Baltimore Medical Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X F Months Days Hours Min. 96 9, 220-10-0576 Oct. 1913 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Pikesville Md. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 228 Sudbrook Lane 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XINo Specify: Specify: 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Swach Dora Kellv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Matthew J. Cremen/ Son 1814 Trenleigh Rd. Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery | 4-26-10 Pikesville, Md. 22. Name and Address of Eacility
Ruck Towson Funeral Home, 21. Signature of Puneral 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TO XIC METABOLIC ENCEPHALOFATY Due to (or as a consequence of): DEHY DEATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ELECTROLYTE ARNORMALITIES. Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐No Month Day Year 5 ☐ Other (specify) 9 Tilnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 ☐ Yes 2 ZNO 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, str et, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

**Physician** /Medical Examiner The law requires that the death certificate be execute P.O. Box 68760

Examine attending physician and for use as the burial-tran Physician/Medical þ Completed Be Certification: To

**Physician** 

Examiner

**Funeral** 

Director

28a-f show ns 23a or 28a-f sho

items

6

"natural"

permit. Pages 1 and 2 should be filed within 72 hc
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any Injury or other traumatic event, the Medical
once.

Director

Funeral

Completed by

Be

ည

Marylan

/Medical

signed by the a cate has been signated by page 2 should b funeral director, this e Hospital or Attending Pi 124 hours after death. e Funeral Director: After t letely filled in by the funera After 1 24 hours a

of Vital Records,

Division

within 2.

D 69278

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ESST, TOWSON, MD

State Registra

Medical

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4a&26perPHYS, G902, 4/27/2010 WS

State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 ORIL Medical Place Pipewood 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRETEMORE . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign NJ inplac **Funeral** 149-12-4481 1 - M 2 - TF Months Davs Hours Min. 84 Yrs Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if tiem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must han matter at a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD Baltimore City Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3918 Cloverhill Rd 21218 **USA**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Signmaker National Forestry Srvc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lorenzo No11 Virginia (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3918 Cloverhill Rd. Baltimore, MD 21218 Eleanor Simonsick / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/22/2010 Ardent Crematory Hanover, MD Signature of Fundral Service License 22. Name and Address of Facility 7522 Connelley Dr. #N. Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 420 Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months 1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Assisted Living Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Spe 28a. Date of injury (Month, Day, Year) 27. Manner Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖵 🇲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) re and title of certific 29c. License number 29b. Signata 29d, Date signed (Month, Day, Year, 205 ma address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Bultimore no 21224 ~ 5 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1 2010 7:40PM Wilhelmina Dolan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Hours Min (Month Pay, Year) 20 89 Mary Land Director 215-18-5316 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore Perry Hall 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 9503 Kingscroft Terrace Unit A 21128 USA items 2 · death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ò þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Specify. Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be ment of Health and Ments John Kammer Minna Trebing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Harris Dolan, Husband 9503 Kingscroft Terrace Unit A Perry Hall, MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 04/26/10 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year this certificate has been signed by the rall director, page 2 should be detached g Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 X No 2 No 1 🗌 Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Certifying Nurse Practioner: To the basis of my howledge death occurred at the time, date and place, and que to the cause(s) and manner ac stated. (Check 29b, Signature and title, 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and add

JACKIE JONES,

31. Date filed (Month, Day, Year)

WILHELMINA

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ess of person who completed cause of death (Item 23a) (Type, Print)

CRNP

20

DHMH 17 Rev 1/2001

**OCME 2006** 

State Registrar Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCME

Donna M. Vincenti, MD

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 24 Daniel Drigan :26 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Towson Gilchrist Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Year 1920 Pennsylvania Months Days Hours Min. 1 □XM 2 □ F July 14 175-01-9543 89 Yrs **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Maryland | Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a 8810 Walther Blvd. Apt.2321 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 ¥ Widowed 4 □ Divorced WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Guidance Counselor Baltimore Co. Schools Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any ininy or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Daniel Drigan Ferko Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Remi Anne Drigan / Daughter P.O. Box 2213 Anna Maria, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Cem. 4/30/10 Maryland Timonium, 4 Donation 5 Other (Specify) 21. Signature of Fund 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the discusse, o shock, or heart failure. List mplication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Of unknown Motostatic Corcinana disease or condition Ct 200 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 1 Yes 2 9 Unknown g 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disorder alliano 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been signed as 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy pace death? certificate h 2 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation neral Director; / filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death continued at the time. date and slace, and due to the gaussis and manner as stated 29b. Signature nd title of certifie PNH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ Carol R. Eskins 2010 1:45 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death
Baltimore Towson Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, ) Year) 1<u>942</u> 1 □ M 2 🖾 F Months Days Hours 048-32-4018 67 Yrs Director Connecticut June Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director Baltimore Baltimore Maryland 1 Yes 2 No 10f. Zip Code 21220 10e, Street and Number 10g Citizen of What Country? United States Funeral 14 Mariners Walkway America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Muriel V. Wallace 2 arol Eskins should be file and Mental H ဂ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Robert J. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Floute Number, City or Town, State, Zip Code) 14 Mariners Walkway Baltimore, Maryland 21220 Mr. Robert A. Eskins/ husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apri<sup>Date</sup> 26, cemetery, crematory or other place)
Evans Funeral Chapel 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 Donation, 5 Other (Specify) 2010 21. Signature of Anneral Service Licer 22. Name and Address of Facility
Peaceful Alternatives
2325 York Road Funeral & & Cremation Ctr., P.A m, Maryland 21093, P.A 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ endonation disease or condition Strongs concer 201 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the funeral director, page 2 should be detached for use as the burnal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed f 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lows 31. Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Curtis Richard Edwards 5:08 A M 2010 Apri] Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/14/1943 9. Birthplace (State or Foreign Country) Virginia Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Hours Director 213-40-0788 66 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1XXYes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 105 Bay Blvd. 21078 USA ıral", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecWhite "natural", 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical socce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Civil Servant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Terry Richard Edwards Rose Zenna Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Edwards / wife 105 Bay Blvd, Havre de Grace, MD 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Darlington Cemetery 4/27/2010 Darlington, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St., Aberdeen, MD 21001 Signatu of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? page 2 should be detached for Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disease 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 24 hours fter death. Funeral Director A 1 Yes 2 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Bactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the F only one) 29b. Signature and title of certific

State Registrar

DHMH 17 Rev 7/2009

M.D -

32. Registrar's Signature

669 Revolution St

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MP

Benjamin Lee,

APR 27

31. Date filed (Month, Day, Year)

0063981

Havre de Grace MD 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 9:10 AM Jessica E. Friedman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Roland Park Place Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 29 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕅 F Months Hours Sept 214-46-9576 98 1911 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 830 West 40th Street 21211 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Social Worker Foster Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esther Walbarsht Harry Freedman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I Carol Siegel, Daughter 184 Summit Street Englewood, NJ 07631 other permit. Pages 1 ar Department of Hea Important: If item 3 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 04/26/10 Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Advanced wiferesselledte carelienascular disease disease or condition resulting in death) Fears /Medical Due to (or as a consequence of) Examiner Years Hyperkusion Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 W No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c Certification: 28d. Describe how injury occurred Injury at Work? or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: ...
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

> Tr Babelle Vac

D. IS ABELLE 31. Date filed (Month, Day, Year) grager Mi)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

013657

MAR TREGOR, 830 W. 40th STREET, BALTIOTORE, MARTLAND 21211

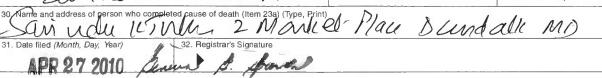
agree 24,20:0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 April **Physician** Helen Marie Filliaux 23, 12;15 P M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Genesis Eldercare - Heritage Center Dundalk 8. Date of Birth (Month, Day, Year) October 9, 1913 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 2 👿 F 215-24-6567 Director 96 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, I'm Medical Exeminer must be notified at 28a-f show 1 ☐Yes 2X No Director Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Weyhill Court 21237 USA Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 years Housewife Own Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Frederick Zander Marie Rommel ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter-In-Law 5 Weyhill Court, Rosedale, Maryland 21237 Joan Filliaux 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Oak Lawn Cemetery 2010 Juneral Service Licensee Signature 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Rartf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEROSCIERVIIL CARDIOVASCULAR DISEASE **Physician** /Medical Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-trans Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery To the Hospital or Attending Physician. The law requires that the death of within 24 hours after death.

To the Luneral Director: After this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for us 3 Ectopic pregnancy Month Vear 5 Other (specify) P.O. 9 Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy of Vital 1 □ Yes 1 ☐ Yes 2 No 2 1 No 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) LE) Weller MID

State Registrar

31. Date filed (Month, Day,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN GAITHER Month 2010 Dril Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1+05 PI Tal Kandallstown North WEST Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** M 2 □ F Months Days Director 19-50-1028 Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 No 10e. Street and Number ò 10g. Citizen of What Country? by Funeral 23a Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed and Mental Hygiene. Is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle ျှ romwe other traumatic f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (1) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Place of Disposition (Name of demetery, crematory or other Department of H Important: If ite any injury or oth 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) gnature of Funeral Service Licensee Funeral Services lallstown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or neart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Gastro Intestinal Bleed Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transil Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Prostate Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 3 Hospina. ... 124 hours affer death. e Furneral Director: After this certificate has I Furneral director, page 2 ? autopsy performed? death? 2 2 No 1 Yes 2 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 2 A No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65843 Loun April, 23,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Addition Kofrouni , 5401 Old Cour Old Court Road, Randallstown, HD 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:45 AM Gittings 2010 John Howard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 105017 17mare Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months (Month, Day, 1 M 2 □ F Hours 68 220-36-5398 Director NUS .08 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 🗆 Yes 2 🖺 No NA MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21215 U.S.A. 3915 Callaway Ave Apt 702 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces?
1 X Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify. Black 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) 2yrsBaltimore City Baltimore City Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julia Ann Coates Howard James Gittings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3236 Tioga Parkway, Baltimore, Md 21215 Julia J. Gittings-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Vet 4/30/2010 Owings Mills, Md Garrison permit. P Departm re Funeral Service Licens March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence o Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 🗆 No 3 🗆 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2: autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 🔎 No ၉ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: Natural 28d. Describe how injury occurred iniury 5 Pending thin 24 hours after death.

the Funeral Director: A pmpleted filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Pr 4/1 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 23 20 Î O 1:15 Leopoldo Gruss ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup>1928 Days Hours Feb. 28, 1 **X** M 2 □ F Argentina Director 024-28-6657 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Maryland Hygiene. Important: If time 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Md. 1 Yes 2 No Baltimore 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? Funeral USA 21234 2609 Ivy Place 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Armed Force Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes Yes, Give 2 X No 1⊠Yes 2□No Specify:Argentina 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Medicine Physician Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margarita Robert Gruss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Gloria Cerino-Gruss/ Wife 2609 Ivy Place Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4-26-10 Towson, Md. Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F Arral Service Licensee 22. Name and Address of Facility son Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PANCREATIC CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or linjury Examine Due to (or as a consequence of) for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 2 No To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2**X** No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗶 Natural 5 Pending 1 🗌 Yes 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the only one 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 2010

State Registrar

2010

Leopoldo Gruss

VALLEY RD.

TIMONIUM, MD 21093

2300 DULANEY

32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 08:55PM Jean Gill Irma APRIL 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Days Jan. 18 Min. 1 M 2 X Maryland 216-16-6781 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 🗌 Yes 2 ី No Baltimore Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21212 Stoneleigh Rd. 808 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Owens Holzer Homer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 808 Stoneleigh Rd. Baltimore, Md. 21212 Mr. Kenneth K. Gill/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 Removal from State 4-28-10 Baltimore, Md. 4 Donation 5 K Other (Spentombment Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. , of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOGENIC disease or condition resulting in death) Due to (or as a consequence of) CORONARY Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). RESPIRATORY that initiated events resulting in death) Last Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Physician/ Medical Examine Examiner

permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other theore.

Physician/

Medical

10a. State

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

Director

. Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. Hart If Ifew 27.5 is marked other than "natural", or Items 23a or 28a-f sho inty or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036



physician s the burial

ours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours af To the Funeral Di completed filled is

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

| 1   | lica                       |
|-----|----------------------------|
|     | /Mec                       |
|     | d by Physician/            |
|     | ρ                          |
|     | rtificate: To Be Completed |
| ı   | Be                         |
| - 1 | မ                          |
|     | ertificate:                |

Medical 29a.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

RICHARD LINTHICUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

32. Registrar's Signature

|  | — V  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 yronths? 1 □ Yes 2 X No 9 □ Unknown | 23d. Date of delivery<br>Month Day Year  |   |  |  |  |  |  |  |  |
| Part II. Other significant condition   | s contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death?  |  |  |  |  |  |  |  |
| RENAL FAIL   | U.R.E.   | 1 Yes 2 \sum No 3 \sup Probably 4 \sup Unknown  |  |  |  |  |  |  |  |
| LACTIC AC  | I DOSIS<br>S THROMBOSIS  | 24a. Was an autopsy performed? 1 ☐ Yes 2 ★ No 1 24b. Were autopsy findings available prior to completion of cause of death? |  |  |  |  |  |  |  |
| 25. Was case referred to medical   | 26. Place of Death (Check only one)  |   |  |  |  |  |  |  |  |
| examiner?<br>1 \sum Yes 2 \textbf{X} No  | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nurs  | ng Home 5 ☐ Residence 6 ☐ Other (Specify)   |  |  |  |  |  |  |  |
| 27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga                            | 28a. Date of injury (Month, Day, Year)  28b. Time of work?  M 1 Yes 2 N  | 28d. Describe how injury occurred   |  |  |  |  |  |  |  |
| 3 Suicide 6 Could no<br>4 Homicide determin  |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)   |  |  |  |  |  |  |  |
| (Check 2 Medical Ex  | Physician: To the best of my knowledge, death occured at the time, date and pla<br>aminer: On the basis of examination and/or investigation, in my opinion, death occu-<br>lurse Practioner: To the best of my knowledge, death occurred at the time, date are | rred at the time, date and place, and due to the cause(s) and manner state  |  |  |  |  |  |  |  |

29c. License number

7601 OSLER DRIVE

31826

29d. Date signed (Month, Day, Year)

TOWSON MARYLAND 21204

4-26-10

State Registrar

20

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19b, per Fh g902 4/27/10 TT
State of Maryland 7 Department of Health and Mental Hygiene

10a-f, per Inf G906 8/5/10 TT

Certificate of Death

Reg. No. 2 | | | State Amend 10a-f, per
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 24 Year 10 Glushakow Leonard 4 10:30AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE ARDEN COURTS PIKESVILLE If Under 1 Year If Under Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 M 2 F Months Days Hours 0470271928 218-22-7323 Director 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Palm Beach 10d. Inside City Limits Funeral Director 10c City Town or Location Boca Raton 1 Yes 2 X No BALTIMORE **PIKESVILLE** MD-10f. Zip Code <sup>10</sup>21261 D CLub Side Drive 10g. Citizen of What Country? 33434 8002 BRYNMOR COURT, USA <del>21208</del> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER AUTOMOBILES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ NOVAKOV **GLUSHAKOW ESTHER** ABRAHAM 19b**84** in Paddress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <del>-8200</del> BRYNMOR COURT, #403, PIKESVILLE, MD 21208 JOAN GLUSHAKOW / WIFE 20a. Method of Disposition
1 M Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date BETH TFILOH CONG. 04/26/2010 WOODLAWN, MD ◆ □ Ponation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC 21. Signature of Funeral Service I REISTERSTOWN ROAD, PIKESVILLE, MD 21208 P rt 1. Enter the disea a proplications that cluse shock, or heart failure. List only one cause on each in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 4/zheiner's Physician/ disease or condition resulting in death) 5 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 1 Yes 2 9 Unknown ate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No certificate | 2 W No uneral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred a er death.

Director: //fter t 1 Matural work? 5 Pending within 24 hours a er death.

To the Funeral Director: Aft completed filled in by the 'un 2 Accident
3 Suicide Investigation Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and otle of certific 29d, Date signed (Month, Day, Year) 00068862 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Circle Mily Kannarkat M.D. 13ciltimore, MD 21224 31. Date filed (Month, Day, Year) 32. Regist State

DHMH 17 Rev 7/2009

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |   |                   | _ For   | State of Maryla  | -                                |   |                              | ınd Mer                        | ital Hygi               | iene                                  |   |
|----------------------------|---|-------------------|---|--|----------------------------------|---|------------------------------|--------------------------------|-------------------------|---------------------------------------|---|
|                            |   | -                 | State Registrar   |  | Cei                              | rtificate of  | Death                        |                                |                         | eg. No. 2                             | 0 12970   |
|                            | Physici   |                   | 1. Decedent's Name (First, Middle, Las  | 51971  | Y                                |   |                              |                                | Date of Death<br>Month  | 199 2                                 | ear () /2:00 PM   |
| No. of Section             | /Medio  |                   | 4a. Facility Name (If not institution, give   | e street and number)   |                                  | 4b. City, Town, o   | r Location o                 | f Death                        | t                       | 4c. County of                         | Death   |
|                            |   |                   | CODDEN C  | Idal.  |                                  | SYKESV  |                              |                                |                         | CARF                                  |   |
|                            | Funeral<br>Director   |                   | 5. Social Security Number 6. \$   | 7. Age (In yrs   | . last birthday)<br>Yrs.         | If Under 1 Year Months Days                                   | Hours 1                      |                                | Date of Birth           | Year 25 9                             | Birthplace (State or Foreign Country)                           |
|                            | p ,   |                   | Usual Residence of Decedent  10a. State 10b. County   | 100.0  | ity, Town or Lo                  | cation  |                              |                                |                         |                                       | 10d. Inside City Limits   |
|                            | shov  | <u>ا</u>          | FL 10b. County  MANATEE   |  | *                                | RSITY PA  | RK                           |                                |                         |                                       | 1 □Yes XXNo   |
|                            | 28a-f   | rect              | 10e. Street and Number  | •  |                                  | 10f. Zip Code   |                              |                                | 11                      | 0g. Citizen of Wh                     | at Country?   |
|                            | 3a or   | Ö                 | 6417 ADDINGTON PL   | ACF  |                                  | 3420  | 1                            |                                |                         | USA                                   |   |
| 9                          | 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Wedleal Evan increment be notified at  | Funeral Director  | 11. Marital Status 1 □ Never Married 2 💢 Married  | 12. Was Decedent Ever in l<br>Armed Forces?<br>1 X Yes 2 □ No<br>If Yes, Give                  |                                  | Was Decedent of Hif Yes, spedfy Cub                           | Hispanic Original, Mexican   | gin? (Specify<br>, Puerto Rica | Yes or No-<br>in, etc.) |                                       | American Indian,<br>White, etc.<br>WHITE                        |
| 93                         | ours a  | d by              | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:   |                                  |   |                              |                                |                         |                                       |   |
| 21215-0036                 | rithin 72 h<br>ne.<br><b>han "natu</b>  | Completed         | 15. Decedent's Ed<br>(Specify only highest grades)<br>Elementary/Secondary (0-12)   | College (1-4or 5+)   | (Give                            | dent's Usual Occup kind of work done DO NOT use retire ENTIST | durina most                  | of working                     | 1                       | 16b. Kind of Busin                    |   |
| 2                          | filed withir<br>Hygiene.<br>other than  |                   | 17. Father's Name (First, Middle, Last,   |  | <u> U</u>                        | -141131   | 18. Mothe                    | r's Name <i>(Fi</i>            | rst, Middle, N          | Maiden Surname)                       |   |
| lan                        | ld be lental ked o  | To Be             | HENRY GLAZ  |  |                                  |   | IDA                          |                                | FINK                    | KELSTEIN                              |   |
| Maryland                   | ges 1 and 2 should be filed within to Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, the  |                   | 19a. Informant's Name/Relationship (  |  |                                  | ng Address (Street<br>ADDINGTO                                |                              |                                |                         |                                       | tate, Zip Code)<br>K,FL 34201                                   |
|                            | s 1 and 2<br>f Health<br>item 27 I<br>other tra   |                   | 20a. Method of Disposition  | 20b.   | Place of Dispo                   | osition (Name of<br>matory or other pla                       | ice)                         | Date                           |                         | 20c. Location - C                     | ity or Town, State  |
| mo                         | Pages<br>nent of l<br>ant: If ite<br>ury or o   |                   | 1  Burial 2  Cremation 3  ☐  #☐Donation 5  Other (Specif  |  |                                  | AEL CEMET   |                              | 4/25/2                         | 2010 V                  | VOODBRID                              | GE, NJ  |
| Baltimore,                 | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 It<br>any injury or other tra<br>once.   |                   | 27. Signature of Funeral Service Licer  |  |                                  | 2. Name and Addre   |                              |                                |                         |                                       | S., INC.<br>, MD 21208  |
|                            |   |                   | 2 a Pirt1. Enter the disease, o sem shock, or heart failure. List only  | lications that caused the dea  | ath. Do not en                   | ter the mode of dyi   | ing, such as                 | cardiac or re                  | spiratory arr           | est,                                  | Approximate<br>Interval Between                                 |
|                            | Physician   |                   | Immediate Cause (Final disease or condition   | a Doment   | ia                               |   |                              |                                |                         |                                       | Onset and Death   |
| -                          | /Medical<br>Examiner  |                   | resulting in death)   | ue to (or as a conse   |                                  |   |                              |                                |                         |                                       |   |
|                            | rted<br>I<br>Insit  | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events | Due to (or as a conse  | equence of):                     |   |                              |                                |                         |                                       |   |
| 8760,                      | cate be executed oblysician and the burial-transit  |                   | resulting in death) Last  | Due to (or as a conse  | equence of):                     |   |                              |                                |                         |                                       |   |
|                            | cate<br>ohy<br>the  | edical            |   | 0  |                                  |   |                              |                                | 1500                    |                                       |   |
| O. Box                     | Physician: The law requires that the death certific<br>this certificate has been signed by the attending print director, page 2 should be detached for use as   | Physician/Me      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of preg<br>1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time o<br>9 ☐ Unknown | tal death 3                      | ☐ Ectopic pregnan☐ Other (specify) _                          | су                           |                                |                         | 23d. Date<br>Mont                     | of delivery<br>th Day Year                                      |
| , P.O.                     | res that the de<br>signed by the s<br>be detached f   | y Ph              | Part II. Other significant conditions   | contributing to death but not re   | esulting in the u                | ınderlying cause gi   | iven in Part I               |                                | 23e. Did to             | bacco use contrib                     | oute to the cause of death?                                     |
| rds                        | quires<br>en sign<br>uld be   | Completed by      |   |  |                                  |   |                              |                                | 1 □ Y                   | es 2∏No 3                             | Probably 4 🗌 Unknown  |
| ဝွ                         | aw rec<br>as bee<br>2 shol  | plete             |   |  |                                  | - <del></del>   |                              |                                | 24a. Was a              | n 24b. W                              | ere autopsy findings available<br>for to completion of cause of |
| æ                          | The la  | E O               |   |  |                                  |   |                              |                                | perfor                  | medi / de                             | eath?<br>□Yes 2□No  |
| ita                        | ian;<br>ertifica  | Be C              | 25. Was case referred to medical examiner?  |  |                                  |   | -                            | of Death (C                    |                         |                                       |   |
| <u>+</u>                   | hysic<br>his ce<br>I direc  |                   | 1 Yes 2 No  | Hospital: 1 ☐ Inpatient 2  |                                  | nt 3 DOA  |                              |                                |                         | ence 6 Othe                           |   |
| טע                         | ing P   | on:               | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day, Year)  | 28b. Time of<br>Injury           | Wo  | uryat<br>ork?<br>⊒Yes 2 □    |                                | I. Describe h           | ow injury occurre                     | d   |
| Division of Vital Records, | Attend<br>death<br>ctor; /<br>y the f   | Certification: To | 2 Accident investigation 3 Suicide 6 Could not be determined  | e 280 Place of Injury . At   | home, farm, st                   |   |                              |                                | Location (S             | treet and Numbe                       | r or Rural Route Number,  |
| Ρ                          | al or A<br>after<br>Dire<br>d in b  | erti              | 4 ☐ Homicide determined   | building, etc. (Spe  | cify)                            |   |                              |                                | City or Tow             | n, State)                             |   |
|                            | To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should | Medical C         | 29a. Certifier 1  | hysician: To the best of my k<br>miner: On the basis of exami<br>and manner stated.            | nowledge, dea<br>nation and/or i | th occurred at the nvestigation, in my                        | time, date a<br>opinion, dea | nd place, and<br>ath occurred  | d due to the a          | cause(s) and mar<br>date and place, a | nner as stated.<br>nd due to the cause(s)                       |
|                            | To the vithin To the complete   | Me                | 29b. Signature and title of certifier   |  |                                  | 29c. Licer  | nse number                   |                                | - :                     | 29d. Date signed                      | (Month, Day, Year)  |
|                            |   |                   | 1 talkyle   | - MD   |                                  | Dos   | 2581                         | 37                             |                         | 4/19/                                 | 10  |
|                            |   |                   | 30. Name and address of person who  |  | em 23a) (Type                    | , Print)<br>397 (   | 1 / /                        | . (                            |                         | .10 01                                | 150   |
| _                          |   |                   | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sig  |                                  | 327   | Nest.                        | min St                         | 6/ 1                    | MU ZI                                 | 2 /   |
| '                          | St  | ate               | or. Date med (Month, Day, Tedi)   | oz. Negistiai s olg  |                                  |   |                              |                                |                         |                                       |   |

DHMH 17 Rev 1/2001

APR 27 2010 Senera S. Jack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Apri.l Physician/ 23 Marvin Dwight Grant Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Social Security Number last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-58-2567 58 Months Hours 1 XM 2 □ F 11<sup>M</sup>7677951 Mary land Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21102 USA 3207 Chestnut Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married Yes 2 XNo 21215-0036 Specify:Black 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Goodwill Industries Customer Service Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Winifred Saunders Marvin Grant 2010 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3207 Chestnut St Manchester, MD 21102 Kevin Grant-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 4.30.2010 Baltimore, MD Baltimore Crematory 4 Donation 5 Other (Specify) APRII. ature of Funeral John I. Williams Funeral Directors 4517 Park Hgts Ave Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ BLADDER CANCER Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 Tes 2 🗆 No MARVIN GRANT been : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has autopsy page 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify) မ 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 1 X Natural 5 Pending 2 Accident
3 Spic Investigation

completed filled in by the funeral director, Hospital

State

Medical

31. Date filed (Mont Registrar DHMH 17 Rev 7/2009

JACKIE JONES,

4 Homicide

29a. Certifie

(Check 29b. Signature and title

6 Could not be

determined

2300 DULANEY VALLEY RD. Registrar's Signatur

s of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

TIMONIUM, MD 21093

1 Yes 2 X No

11:35

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month April **Physician** HOR7ON 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Landalistown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-8-1927 Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Months Days 216-20-975 Director 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number ō 23a Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 ☑No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1950 Specify. ò 3 Widowed 4 Divorced "natural" Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglenc Important: If Item 27 is marked other that any injury or other traumatic event, Ins. Jones. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hor ပ 19b. Mailing Address (Street and Number 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cometery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State HOOO Marriottsville MD Mn C. Breene Funeral Services 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice m) 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2☐ 5#/Outpatient 3☐ DOA 1 Yes 2 Dyd 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6265 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randy 11 HOWN l court 000

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) APR 27 2

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2 Day 2010 9:10 AM David April Oscar Heinonen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2851 Hollins Ferry Road Baltimore
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Director 49 07/06/1960 212-80-1364 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ages 1 and 2 should be filed within 72 hours after death with the Maryla nt of Health and Mental Hygiene.
If flem 27 S marked other than "natural", or items 23a or 28a-f show or of other thaumatic event, he Maddal Evanin 1 ☑ Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2851 Hollins Ferry Road Funeral 21230 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ĺ2 Heavy Equipment Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Nellie Oscar William Katherine Walker Heinonen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hollins Ferry Rd, Baltimore, MD 21230 Connye Heinonen / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If Its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 104/26/2010 | Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Licens 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) 0 5 /Medical Due to (or as a consequence 11) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit Exami Due to (or as a consequence of) O. Box 68760, certificate be Physician/Medical as the IF FEMALE use If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Month Year 5 ☐ Other (specify) the a ☐Yes 2☐No detached 9 Unknown σ. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D40824

State Registrar

DHMH 17 Rev 1/2001

eted cause of death (Item 23a) (Type, Print)

32. Registra Signa

Ruschers

26/ 2010

21202

Baltonor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 2010 HARTMAN 04 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RAVEN BALTIMORE LOCH BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral . Age (In vrs. last birthday) 8. Date of Birth 1 □ M 2 🛣 Months Oct. 7, 1925 220-14-5258 84 maryland Director Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Md Baltimore Essex 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8720 Kelso Drive 21221 USA ural", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes Yes, Give 2**X** No Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wyatt Annie Barrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna McCann-daughter 53 King Richard Ct. Balto. Md. 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4/29/2010 Baltimore, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto.Md.2122 Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Physician ENAL FAILURE disease or condition Medical resulting in death) Examiner INFECTION RINARY Sequentially list conditions, Examine / D if any, leading to immediate cause. Enter Underlying ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit SCULAR Cause (Disease or iinjury that initiated events STAGE To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-transi FARS Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day 1 ☐ Yes 2 ≥ 9 ☐ Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 🛣 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 X Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AC 0000 262 27 2010 3 30. Name and address 6 person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

EMGE

Year)

31. Date filed (Month, Day, Ye

| 10-03106<br>Margaret Victoria H   | Please Type or Print in Black Indel   |  | egible.  |
|---|---|--|--|
| Margaret Victoria n   | 1- For State Certific   | nent of Health and Mental Hygiene cate of Death  | 2010 1297  |
| Physician/  |   | 2. Date of De<br>Month   | ath 3. Time of Death   |
| Medical Examine   | MARGARET VICTORIA HYNSON  4a. Facility Name (if not institution, give street and number)                                | April 21,  |  |
|   | 3566 Horton Avenue  | Baltimore  | 4c. County of Death  |
| Funeral   | 5. Social Security Number 6. Sex 7. Age (In yrs. last bit   | thday) If Under 1 Year If Under 24Hrs. 8. Date of E  Months Days Hours Min.                          | irth(MM/DD/YYYY) 9. Birthplace (State or Foreign                       |
| Director  |   | 59 Yrs. JUNE 1   | 7,1950 Country) VIRGINIA   |
| sun's   | Usual Residence of Decedent 10a. State 10b. County 10c. City, Towr  | n or Location  | 10d. Inside City Limits  |
| Maryland 28a-f show d at once.  | MD. BALTIMO   | RE CITY  | 1 X Yes 2 No   |
| 72 hours after death with the Maryland na "natural", or items 23a or 28a-1 she al Examiner must be noted feed by Funeral Director   | 10e. Street and Number  | 10f. Zip Code  | 10g. Citizen of What Country?  |
| with the be notified be notified be notified be notified be notified by the peral D   |   | 21225  13. Was Decedent of Hispanic Origin? ( Specify Yes or N                                       | UNITED STATES  o- 14. Race - American Indian, Black,                   |
| death with  | 1 Never Married 2 Married Armed Forces? 1 Yes 2 No  | If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  | White, etc.  |
| s after or rall, on tiner in by F.  | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  | 1 Yes 2 No specify:  | Specify: WHITE   |
| 2 hour l'antu   | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)       | Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry   |
| 5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan  | . 12 +4 GR  | OCERY MANAGER  | GROCERY  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyggene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director |   | 18.Mother's Name (First, Middle,   |  |
| 212<br>Suld be<br>I Mentz<br>in even<br>To B  |   | ALBERTA b. Mailing Address (Street and Number or Rural Route Nu                                      | TAYLOR mber, City or Town, State, Zip Code)                            |
| Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.   |   | 566 HORTON AVE. BALTIMORE,   |  |
| Ore,<br>ses 1 ar<br>of Hez<br>If ites   | 1 Rurial 2 X Cremation 3 Removal from State Crema   | of Disposition (Name of cemetery, tory or other place) TIC CREMATORY APR 24,201                      | 20c. Location - City or Town, State                                    |
| Baltimore,<br>permit. Pages 1 ar<br>Department of Hee<br>Important: If ite  | 4 Donation 5 Other Specify:  21 Sgo itus of Funeral Service Licenses  |  | GLEN BURNIE,MD.  |
| Ba<br>Perm<br>Depa<br>Inju  | taline am Clarket   | 22. Name and Address of Facility AMBROSE FU<br>1328 SULPHUR SPRING RD. A                             |  |
| Physician   | 23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line. |  |  |
| /Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic  Due to (or as a consequence of):   | cardiovascular disease   | Death  |
|   | Sequentially list conditions,  b  |  |  |
| iner  |   |  |  |
| ted nsit Examine  | (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):                    |  |  |
| n and   | G. AMENDED  |  |  |
| A 17 17 18  | Z3a,PII, 27,  IF FEMALE: 23c. If yes, outcome of pregnancy  | per ME g902 4/28/10 TT   | 23d. Date of delivery  |
| Box 68760, e death certificate be e the attending physician of for use as the burial hysician/Medi:   | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time of death                             | Fetal death 3 Ectopic pregnancy  | Month Day Year   |
| Box<br>e death the atter<br>ed for u  | 1 Yes 2 No 9 V Unknown 9 Unknown  | 5 Other (Specify)  |  |
| Records, P.O. Box<br>The law requires that the death<br>cate has been signed by the atte<br>page 2 should be detached for u   |   |  | obacco use contribute to the cause of death?                           |
| of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach on: To Be Completed by P.   | Breast carcinoma  | 1Ye  | s 2 No 3 Probably 4 V Unknown  an 24b. Were autopsy findings available |
| Records, The law requires ficate has been sign. Page 2 should be Completed  |   | auto   | psy prior to completion of cause of death?                             |
| I Re tifficate or. page   | 25. Was case referred to medical  | 1 ✓ Yes<br>26.Place of Death (Check only one)  | 2 No 1 Yes 2 No  |
| Vital ysician ysician director director   | examiner?   | Othor:   | Residence 6 🗸 Other: Scene   |
| Division of Vital Records, tal or Attending Physician: The law requints after death.  al Director: After this certificate has been siled in by the flueral director, page 2 should bertification: To Be Completed   | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b.   |  | how injury occurred  |
| Division o<br>ospital or Attending<br>hours after death.<br>neral Director: Aft<br>y filled in by the func<br>Certification:  | 2 Accident Investigation  | 1 Yes 2 No   | 01   |
| Divi  | 3 Suicide 6 Could not be determined (Specify)   | arm, street, factory, office building, etc. 28f. Location (<br>or Town, 3                            | Street and Number or Rural Route Number, City State)                   |
| or by find the base   | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea   | ath occurred at the time, date and place, and due to the cau   |  |
| To the H. within 24 To the Fu completel   | and manner stated.  | nvestigation, in my opinion, death occurred at the time, date  |  |
|   | 29b. Signature and title of certifier   | 29c. License number O.C.M.E.   | 29d. Date signed (Month, Day, Year)  April 22, 2010                    |
|   | 30. Name and address of person who completed cause of death (Item 23a)  |  |  |
|   |   | Penn Street, Baltimore, MD 21201   |  |
| State<br>Registrar  | 31. Date filed (Month, Day Year) 7 2010 32. Registrar's Signature   | base   |  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month APR. ARVIN IAMES 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY HOSPITAL 5. Social Security Number 4/1/L If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign MAY 26, Ye Months Days Hours Min Country) MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2267½ PENTLAND DR 21234 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. 11 Marital Status Armed Forces? 1 ☐ Yes 2 ☒ No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married Specify: BLACK 1 Yes 2 K No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEONARD BASE EVOLA MAE HARVIN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC BOATWRIGHT/BROTHER 2267号 PENTLAND DR., BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/18/2010 ARDENT HANOVER, MD Signature of Funeral Service Lic ee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease, or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List ly one cause on each line Immediate Cause (Final disease or condition resulting in death) Kof Known Due to (or as a consequence of) Sequentially list conditions, if any loading to him solutions. Enter Underlying Cause (Disease or linjury Due to for as a por securior of that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 4 Pregnant a 9 Unknown 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 1 Yes 2 No Month Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? etes mellitus-Type2 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Physician/ Medical Examiner

Examine

Physician/Medical

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Completed

Be

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Certificate:

Medical

1 Natural

2 Accident
3 Suicide
4 Homicide

only one)

29b. Signature and title of certifies

29a. Certifier

Physician/

Examiner

**Funeral** 

**Director** 

28a-f shov

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23a

items

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"natural",

and Mental Hygiene.

permit. Page 1 and 2 st Department of Health a Important: If item 27 is

injury or

any

72 hours after death

Maryland 21215-0036

Baltimore,

Director

Funeral

δ

Completed

Be

ဂ

other traumatic event, the Medical Examiner must be notified at

Medical

requires that the death certificate be executed physician a s the bunal-1 attending p signed by the a The law

Box 68760

P.O.

Division of Vital Records,

Hospital or Attending Physician:

page 2 should has certificate this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending

determined

28a. Date of injury (Month, Day, Year) Investigation 6 Could not be

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

17202

28c. Injury at

work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

16

10

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEEZ M.D.

5. DANGM.D. EN TIMORE APR 27

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Hackett 2010 Mary 11:10 a<sup>M</sup> April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hospice Gilchrist Towson . Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Month, Day, Year) -19-1914 1 □ M 2 🔀 F Months Hours Min 178-01-1424 96 Director Usual Residence of Decedent 23a or 28a-f show ist be notified at 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director MD Baltimore 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 U.S.A. must 3310 Benson Avenue Apt. items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Examiner Black. White, etc. , or 1 Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: . Page 1 and 2 should be filed within 72 hours afti trnent of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", jury or other traumatic event, the Medical Exai Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Goetze's meat cutter 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Lososkie Walter Mieczkowski Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 9650 Longs Mill Road Rocky Ridge, Md. James G. Hackett 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4-26-10 Baltimore, Maryland Oak Lawn Cem. 4 ☐ Donation 5 🙀 Other (Specify) Entomb 22. Name and Address of Facility Charles S. Zannino Lic. Mort Conkling Street Balto. Md. 21224 23a. Part 1. Enter the cisease, or complications that caused shock, or he nt failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Fin disease or condi-Ph sician/ reprova Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): sician and burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the l IF FEMALE: use Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No for Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 WOther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Da</sup>2010 Physician/ Apronth 1 7:54P 16, MARCIA CLAFLIN HALL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson 2004 Ruxton Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Febr. 20 Country)
Wisconsin Days Hours 1 □ M 2 🕅 F 387-30-7361 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore Towson 1 ☐ Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 Completed by Funeral 2004 Ruxton Rd. United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) teacher education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Foster Claflin Rosa M. Neevel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F.C. Hall/son 21204 6511 Darnall Rd. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Green Mount Crematory Apr. 20,2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, MD 2 Approximate Interval Between Onset and Death 23a. Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph\_sician/ Medical resulting in death) Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by sate has been significant base 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an Chroni 66structive ulmonary prior to completion of cause of certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 5  $\square$  Pending /i Natural Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 🗋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director; After to completed filled in by the funera

Chillan 20907 111) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hatham 31. Date filed (Month, Day, Year) sistrar's Signature Registrar

only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Eileen Higham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|          |   |                 | For State Registrar  | State of Ma  | -                                     | epartme<br>Certifica                             |                     |                               | nd Mer                     | , ,                                   | jiene<br>leg. No?             | In                           | 129   | 79             |
|----------|---|-----------------|--|--|---------------------------------------|--|---------------------|-------------------------------|----------------------------|---------------------------------------|-------------------------------|------------------------------|---|----------------|
| Ų        | Physici   | ₩<br>an         | Decedent's Name (First, Middle, Last)  |  |                                       |  |                     |                               |                            | Date of Dea<br>Month                  | th                            | Year                         | 3. Time of D                                |                |
| *        | /Medic  | al -            | EILEEN H  4a. Facility Name (If not institution, give stre   | GHAM   |                                       | 4b. Cit  | ty, Town, or        | Location of                   |                            | oril 2                                | 5, 201                        | 0<br>nty of Death            | 5:53A                                       | M              |
|          | Examilia  | er<br>          | Roland Park Place  |  | ·                                     | Bal  | timor               | e                             |                            |                                       | No                            | ne                           |   |                |
|          | Funeral<br>Director   |                 | 5. Social Security Number 6. Sex 1 M   | 2 F 88   | (In yrs. last birth                   | rs. Month  |                     | If Under 24<br>Hours          | Min. Mar                   | Date of Birth<br>(Month, Day<br>CD 18 | , 1922                        | 9. Birthp<br>WiSCO           | lace <i>(State or</i><br>onsin              | Foreign        |
|          | and w.  |                 | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town                       | or Location                                      |                     |                               |                            |                                       |                               | 1                            | 0d. Inside City                             | / Limits       |
|          | e Maryl<br>a-f sho<br>Ilfied a  | ctor            | Maryland None  |  | Baltimo                               | re   |                     |                               |                            |                                       |                               |                              | XX Yes                                      | 2 □ No         |
|          | with the<br>a or 28<br>be no  | Dire            | 10e. Street and Number<br>830 West 40th Street   |  |                                       |  | Zip Code            |                               |                            | 1                                     | 10g. Citizen d<br>USA         |                              | itry?                                       |                |
|          | death   | Funeral Directo | 11 Marital Status 12.  | Was Decedent E   | ver in U.S.                           | 13. Was Dec                                      |                     | spanic Origi                  | in? (Specify               | Yes or No-                            | 14. R                         | ace - Americ                 |   |                |
| 36       | be filed within 72 hours after death with the Maryland that lygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Fu           | 1 ☐ Never Married 2 ☐ Married  3 XX Widowed 4 ☐ Divorced   | Armed Forces?  1 Yes AN No If Yes, Give Year or Dates: | o                                     |  | XXNo                | Specify:                      | T dono Tilo                | an, 0.00.j                            | Spec                          | lack, White,                 | hite  |                |
| 5-0036   | 72 hou<br>natura<br>ilcal E   | eted            | 15. Decedent's Educati<br>(Specify only highest grade co   | ion  | 16a. [                                | Decedent's U:<br>'Give kind of t<br>life. DO NOT | sual Occupa         | ation<br>Juring most o        | of working                 |                                       | 16b. Kind of                  | Business/Inc                 |   |                |
| 12       | within iene.  than "I   | Completed       | Elementary/Secondary (0-12)  | College (1-4or 5+                                      | -}                                    | sychol   |                     | )                             |                            |                                       | Socia                         | l Serv                       | vices                                       |                |
| מ        | be filed<br>al Hygi<br>dother   | Be C            | 17. Father's Name (First, Middle, Last)  | -  |                                       | <u> </u>   |                     |                               |                            |                                       | Maiden Surn                   |                              | 1005  |                |
| Z        | should tund Ment  | 2               | Francis Moss  19a. Informant's Name/Relationship (Type.  | Print)   | 19h                                   | Mailing Addre                                    | ss (Street a        |                               |                            | esheim                                |                               | n State Zin                  | Code)                                       |                |
| <u></u>  | and 2 sho<br>ealth and<br>n 27 Is ma  |                 | Daniel Higham  | Sc   | - 1                                   | West   |                     |                               |                            |                                       | -                             |                              |   |                |
| nore     | Pages 1 nent of He nt; If iten  |                 | 20a. Method of Disposition  1 Burial 2 Cremation 3 Rem   | oval from State  | 20b. Place of local cemetery  GreenMo | , crematory o                                    | r other place       |                               | Date<br>oril 27            |                                       | 20c. Location                 | -                            | <sub>wn, State</sub><br>Iarylan             | d              |
| Saltimor | permit. Pages 1 and 2 should<br>Department of Health and Mer<br>Important; If item 27 is marke<br>any injury or other traumatic<br>once.                                  |                 | 2 Signature of Funeral Avae Livensee   | 1/.  | A -                                   |  |                     |                               |                            |                                       |                               |                              | al Hom                                      |                |
| מ        | Per E P   | 22              | Wines Lynn   | renou  | ew)                                   |  |                     |                               |                            |                                       | e, Mar                        | yland                        |   |                |
|          | Rhysician   | 17              | 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only ore of Immediate Cause (Final disease or condition | cause on each line                                     | €.                                    | ry u.c   |                     |                               |                            |                                       | d. 15e                        | ast                          | Approximate<br>Interval Betw<br>Onset and D | een<br>eath    |
|          | /Medical<br>Examiner  |                 | resulting in death)  | Due to (or as a  | consequence of                        | f):  |                     | 1 001                         | 111011                     |                                       | 0.130                         | 450                          |   |                |
|          |   | Jer             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury                        | 1  | consequence of                        | f):  | -                   |                               |                            |                                       |                               |                              |   |                |
| b.       | be executed<br>ician and<br>burial-transit  | Examine         | Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a  | consequence of                        | F) -   | <u> </u>            |                               |                            |                                       |                               |                              |   |                |
| 2/00,    | sate be executed obysician and the burial-transit   | lical E         | d.   | 200 10 (0) 40 4  |                                       | · · · · · · · · · · · · · · · · · · ·            |                     |                               |                            |                                       |                               |                              |   |                |
| ŏ        | ertificat<br>ling phy<br>e as th  |                 | IF FEMALE:   |  |                                       |  |                     |                               |                            |                                       |                               |                              |   |                |
| DOX      | law requires that the death certificate as been signed by the attending priys! 2 should be detached for use as the I  | Physician/Me    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No   | If yes, outcome p  1 Live birth 2  4 Pregnant at t     | Fetal death                           | 3 □Ectopic<br>5 □ Other                          |                     |                               |                            |                                       |                               | Date of delive<br>Month      | ,   | ear            |
| 7.<br>Ö  | at the date of the etached  | Physi           | 9 Unknown  | 9□Unknown  |                                       |  |                     |                               |                            | 00 Pili                               |                               |                              |   |                |
| ds,      | uires th<br>signed<br>Id be d   | ρ               | Part II. Other significant conditions contrib  |  | t not resulting in                    | the underlying                                   | cause give          | n in Part I.                  |                            |                                       | bacco use co<br>es 2∐ No      |                              | ne cause of de<br>pably 4 U                 | ath?<br>nknown |
| ecords   | law req<br>as beer<br>2 shou  | Completed       |  |  |                                       |  |                     |                               |                            | 24a. Was a                            |                               | b. Were auto                 | psy findings a                              | vailable       |
|          | n: The licate har, page   |                 |  |  |                                       |  |                     |                               |                            | perfor                                | med?<br>2 No                  | death?                       | mpletion of ca                              | 250 01         |
| VICAL    | ysiciai<br>is certii<br>directo   | To Be           | 25. Was case referred to medical examiner?  1 Yes 2 Yoo Hos  | pital:<br>1  | t 2 🗆 ER/Outp                         | patient 3 🗆 I                                    | DOA Othe            | r-                            |                            | heck only or<br>5 ☐ Resid             | ne)<br>ence 6 □C              | Other (Specif                | v)  |                |
| 0 10     | ding Physician: The law n. After this certificate has funeral director, page 2.8  |                 | 1 Natural 5 □ Pending  | 28a. Date of Injury<br>(Month, Day                     |                                       | jury   | 28c. Injury<br>Work | at<br>?                       | 28d.                       |                                       | ow injury occ                 |                              | ,,  |                |
| VISION   | Attend<br>r death<br>ector:<br>by the f   | Certification:  | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of injur<br>building, etc.                  | y - At home, farr                     | M<br>n, street, fact                             |                     | /es 2□N                       |                            |                                       |                               | mber or Rura                 | ıl Route Numb                               | oer,           |
| בֿ       | oital or<br>urs afte<br>eral Dir<br>illed in  |                 |  |  |                                       |  |                     | 9.50(95.T)                    |                            | City or Tow                           |                               |                              |   |                |
|          | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,           | Medical         | 29a. Certifier 1 ☐ Certifying Physicl (Check only one) 2 ☐ Medical Examiner  | an: To the best of<br>On the basis of and manner state | examination and                       | death occurre<br>/or investigati                 | on, in my op        | ne, date and<br>pinion, death | d place, and<br>h occurred | due to the dat the time, d            | cause(s) and<br>date and plac | manner as s<br>e, and due to | tated. the cause(s)                         |                |
| _        | To the vithin To the committee of the the the the the the the the the the   | Z               | 29b. Signature and title of certifier  | n O  |                                       | 2  | 29c. License        | number                        | )                          | 2                                     | 29d. Date sig                 | ned (Month,                  | Day, Year)                                  | \              |
|          | 12  |                 | 30, Name and address of person who comp  | leted cause of dea                                     |                                       | ype, Print)                                      |                     |                               | 0 1                        | \                                     | Thurt .                       | db,                          | 2010  | ′              |
|          | 10  |                 | Hilory Don "   | N.D.   | 5901                                  | NOSTY  | · CH                | avle                          | 454                        | reet                                  | bat                           | timor                        | W WW  | Yland          |
|          | Sta<br>Registr  |                 | 31. Date filed (Month, Day, Year)  | 32. Registrar  | s Signature                           | hole   | 1                   |                               |                            |                                       |                               |                              |   |                |
|          |   |                 |  | 1 11 -4 24 3-4   | 1 1                                   | CAST SAFERY                                      |                     |                               |                            |                                       |                               |                              |   |                |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 25<sup>ay</sup> 2010ar 11:30 AM Hattie Lucille Hawkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore None St. Agnes Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months Days Hours May 26, 1917 92 MD Director 216 20 8254 Usual Residence of Deceden shov 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🖾 No MD Ellicott City Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21043 4322 Brittany Drive United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black White etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White Completed 3 ▼ Widowed 4 □ Divorced Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie M. Burdette of Health and Mente fitem 27 is marked r other traumatic e Joseph Melvin Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 st tment of Health a tant: If item 27 is Diane Shoup - Niece <u> 20804 Noble Terrace Apt. 316 Potomac Falls, VA 20165</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gard, 4-30-2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 6 days <sup>C</sup>nysician, Cerebrovascular Accident Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 3 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident 3 Suicide Investigation To the Funeral Director completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier ettifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) WIL D0062634 April 25, 2010

12

DHMH 17 Rev 7/2009

State Registrar 10802 Hickory Ridge Rd. Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mateen Awan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2/ per doc g902 4-27-10 vt

| Ç              |  |                  | For State  |                                       | State of M   | •                                     | partment of the control of the contr |  | Mental Hy                            |                           | 0.1.0   | 10001  |
|----------------|--|------------------|--|---------------------------------------|--|---------------------------------------|--|--|--------------------------------------|---------------------------|---|--|
|                |  |                  | Registrar  1. Decedent's Name (F.  | irst, Middle, La                      | st)  |                                       |  | Doutin                                   | 2. Date of De                        |                           | <del>2010</del>                                       | 3. Time of Death                                   |
|                | Physici  |                  | ANN  | E 4,                                  | ARTGE  |                                       |  |  | APR.                                 | 2 Day                     | 2010  | 11.35 AM   |
| -              | /Medio<br>Examir   |                  | 4a. Facility Name (If no   |                                       |  |                                       | 4b. City, Town, o  | or Location of Deat                      |                                      | 4c. C                     | ounty of Death  | 1  |
| -              |  |                  |  |                                       | ATIPLOT  |                                       |  | OTZIIA                                   |                                      |                           | SALTIL  |  |
|                | Funeral  |                  | 5. Social Security Numb  | 1                                     | Sex 7. Ag  | je (In yrs. last birtho<br>Yrs        | Months   Davs  |  | (Month, D                            |                           | 9. Birthp<br>Coun                                     | place (State or Foreign<br>htry)                   |
|                | Director   |                  | 181-14-749<br>Usual Residence of Dec   | 33                                    | - 41   | 89 '''                                | .  |  | 03/23/                               | 1921                      |   | PA   |
|                | yland<br>yland   |                  |  | b. County                             |  | 10c. City, Town o                     | Location   |  |                                      |                           | 1   | 0d. Inside City Limits                             |
|                | a-fsl  | ctor             | MD   | Baltimo                               | ore  | Gwynn                                 | 0ak  |  |                                      |                           |   | 1 Yes 2 No   |
|                | ith the  | Dire             | 10e. Street and Number   | r                                     |  |                                       | 10f. Zip Code  |  |                                      | 10g. Citize               | en of What Coun                                       | itry?  |
|                | ath w  | Funeral Director | 6825 Camp  | field I                               | T  | . 11KT                                |  | .207                                     |                                      | Ur                        | ited St   |  |
|                | er de  | ine              | 11. Marital Status   | OF Mandad                             | 12. Was Decedent<br>Armed Forces?                  | Ever in U.S.                          | <ol><li>Was Decedent of I<br/>If Yes, specify Cub</li></ol>  | Hispanic Origin? (S<br>an, Mexican, Puer | Specify Ye's or N<br>to Rican, etc.) | 0- 14                     | <ol> <li>Race - Americ<br/>Black, White, e</li> </ol> | an Indian,<br>etc.                                 |
| 36             | rs aft   | by F             | 1 ☐ Never Married 3 ☐ Widowed 4 ☐  |                                       | 1 ∐Yes 2 [X] If Yes, Give Year or Dates:           | NO                                    | 1 □Yes 2 ☑ No  | Specify:                                 |                                      | s                         | Specify: Whi  | te   |
| 21215-0036     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or items 23a or 28a-f show<br>ont, the Modkest Everified at   | Completed        | (215.  | Decedent's E                          | ducation   | 16a. D                                | ecedent's Usual Occu   | pation                                   | ud al m. m.                          | 16b. Kind                 | d of Business/Ind                                     | dustry   |
| 21             | within 7<br>ene.<br><b>than</b> "n   | lg l             | Elementary/Secondar  |                                       | ade completed) College (1-4or t                    | 'Ii                                   | ive kind of work done<br>ie. DO NOT use retire   | ed)                                      | rking                                | -                         |   |  |
|                | filed wi<br>Hygier<br>ther th  |                  |  |                                       | 1 yr.  |                                       | Secretari  |  | /F:                                  |                           | rtment  | Store  |
| and            | be fill  | Be               | 17. Father's Name (Firs  |                                       |  |                                       |  | 18. Mother's Na                          | _                                    |                           | urname)   |  |
| Maryland       | 2 should be f<br>and Mental<br>is marked or<br>aumatic eve   | 은                | 19a. Informant's Name  | Humber                                |  | 10h M                                 | ailing Address (Street   | Iva                                      | Fraze                                |                           | Town State 7in  | Cadal  |
| Ma             |  |                  | Mrs. Patri   |                                       |  |                                       | ,  | toak Cou                                 |                                      |                           |   | 1234   |
| ē,             | s 1 and 2<br>f Health<br>item 27 i   |                  | 20a. Method of Disposit  | tion                                  |  |                                       | sposition (Name of crematory or other pla  |  | Date Fall                            |                           | ation - City or To                                    |  |
| Baltimore,     | permit. Pages 1 and<br>Department of Health<br>Important: If item 27<br>any injury or other th<br>once.  |                  | 1 □ Burial 2 🔁 C<br>4 □ Donation 5 □   | remation 3 ☐<br>☐Other <i>(Specil</i> | Removal from State                                 |                                       | c Cremator   | 1.7.72                                   | 8/2010                               | Glen                      | Burnie  | , MD   |
| alti           | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                  | 21. Signature of Funera  |                                       |  | MULATICE                              | 22. Name and Addre   | / = //                                   | ingletor                             | Fune                      | ra1 & C   | remation   |
| <u> </u>       | Dep any any any  |                  | Mill   | C.                                    | (-5./.   | M01121                                | Services P   |  |                                      |                           |   |  |
|                |  |                  | 23a. Part1. Enter the d<br>shock, or heart fa  | isease, or com<br>ilure. List only    | one cause on each li                               | d the death. Do not<br>ne.            | enter the mode of dy   | ing, such as cardia                      | c or respiratory                     | arrest,                   |   | Approximate<br>Interval Between<br>Onset and Death |
| - 19           | Physician  |                  | Immediate Cause (Fina disease or condition   | al                                    | -a. 10   | XIC M.                                | e tobolic  | 2 ence                                   | Miclo                                | path                      |   | Onset and Death                                    |
|                | /Medical<br>Examiner   |                  | resulting in death)  | •                                     | Due to (or as                                      | a consequence of):                    | nal Fa   | 1  | F 3                                  | - 3                       |   |  |
|                |  | e.               | Sequentially list condition if any, leading to immediate   | ins<br>diate                          | D  | a consequence of):                    | hat for  | · · · ·                                  |                                      |                           |   |  |
|                | uted<br>d<br>ansit   | Examiner         | if any, leading to immed<br>cause. Enter Underlyin<br>Cause (Disease or inju-<br>that initiated events | ng<br>ry                              | ,  | . ,                                   |  |  |                                      |                           |   |  |
| o,             | cate be executed<br>physician and<br>the burial-transit  |                  | resulting in death) Last   |                                       | Due to (or as                                      | a consequence of):                    |  |  |                                      |                           |   |  |
| 68760,         | ate be<br>hysici<br>he bu  | edical           |  |                                       | d  |                                       |  |  |                                      |                           |   |  |
|                | ertific<br>ling p<br>e as t  |                  | IF FEMALE:   |                                       |  |                                       |  |  |                                      |                           |   |  |
| Вох            | leath certi<br>attending<br>for use a  | ian/             | 23b. Was decedent pre<br>in the past 12 mor  | nths?                                 | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a | 2 Fetal death                         | 3  Ectopic pregnant  | су                                       |                                      | 23                        | Bd. Date of delive<br>Month                           | ery<br>Day Year                                    |
| Ö              | that the dened by the detached   | Physician/N      | 1 □Yes 22 No<br>9 □ Unknown  |                                       | 9 Unknown  | it time of death                      | 5 Li Other (specily) _   | -  |                                      |                           |   |  |
| σ,             | that<br>ned by<br>deta   |                  | Part II. Other significar  | nt conditions                         | contributing to death b                            | ut not resulting in th                | e underlying cause gi  | ven in Part I.                           | 23e. Did                             | tobacco use               | e contribute to th                                    | he cause of death?                                 |
| Vital Records, | w requires<br>s been sign<br>should be   | ed by            |  |                                       |  |                                       |  |  | 1 🗆                                  | ]Yes 2□                   | No 3□ Prob  | bably 4 Unknown                                    |
| O<br>O         | e law re<br>has bee<br>le 2 sho  | Completed        |  |                                       |  |                                       |  |  | 24a. Wa                              |                           | 24b. Were auto  | psy findings available                             |
| R              | The I  | E                |  |                                       |  |                                       | -  |  | peri                                 | opsy<br>formed?<br>2021No | death?<br>1 □Yes                                      | mpletion of cause of<br>2 □ No                     |
| /ita           | siclan; The<br>certificate h<br>rector, page   | Be (             | 25. Was case referred texaminer?   | to medical                            |  |                                       |  |  | ath (Check only                      |                           |   |  |
| of \           | Physic<br>this c   | ၉                | 1 □ Yes 2√X No   |                                       | -  | ent 2 ER/Outpa                        | MICH G DOA   |  | Home 5 ☐ Res                         |                           |   | ý)   |
| n C            | ding F<br>h.<br>After<br>funera  | ioi              | 27. Manner of Death  1 Natural 5 2 Accident  | Pending                               | 28a, Date of Inju<br>(Month, Da                    |                                       | ry Wo  | iry at<br>rk?<br>]Yes 2  □No             | 28d. Describe                        | how injury                | occurred  |  |
| Division       | death<br>death<br>ctor:<br>y the   | licat            | 3 🗌 Suicide 🔫  | investigation                         | e lana Blanc of Ini                                | urv - At home, farm                   | street, factory, office  | Tes ZINO                                 | 28f. Location                        | (Street and               | Number or Rura  | al Route Number,                                   |
| Ξ              | al or Attendii<br>after death.<br>I Director: A<br>d in by the fu  | Certification:   | 4 Homicide   | determined                            | building, el                                       | c. (Specify)                          | ,,   |  |                                      | own, State)               |   | ,  |
|                | To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit |                  | (Check only 2  | Certifying Pl                         | nysician: To the best<br>miner: On the basis of    | of my knowledge, of examination and/o | eath occurred at the to  | time, date and place                     | ce, and due to the                   | e cause(s) a              | and manner as s                                       | stated. o the cause(s)                             |
|                | the hin 24   | Medical          | one)   |                                       | and manner st                                      | ated.                                 |  | se number                                |                                      |                           | signed (Month,  |  |
| _              | <b>6</b> 월 6 일   |                  | 29b. Signature and title   | Certifier                             | MD   |                                       | 29C. Licens  |  | 753                                  |                           |   | Day, rear)   |
| •              |  |                  | 30. Name and address   | of person who                         | Completed assess of a                              | leath (Itam 22a) /Ti                  | ne Print)  |  | 157                                  |                           | - 44  | ~~(~   |
| _              |  |                  | VENIGAT  | 4 17                                  | FOOTMA   | 25 NI                                 | DITHWEN  | 5 HOS/                                   | I TA1                                |                           |   |  |
|                | Sta  | te               | 31. Date filed (Month, E   | Day, Year)                            | 32. egict  | rar's Signature                       |  |  |                                      |                           |   |  |
|                | Registr  | ar               | AP   | R 27 20                               | 110 Sener  | N B. X                                | barker   |  |                                      |                           |   |  |
| DH             | MH 17 Rev 1/2  | 001              |  |                                       | eq.  | - 4                                   |  |  |                                      |                           |   |  |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |                  | For State  | State of N   | Maryland / [                                    |                                    |                       |                  | and M         | lental Hy                       | giene      | 2011                         | ^             | 10000                               |
|----------------------------|--|------------------|--|--|---|------------------------------------|-----------------------|------------------|---------------|---------------------------------|------------|------------------------------|---------------|-------------------------------------|
| _                          |  |                  | Registrar  1. Decedent's Name (First, Middle)  | - Loot)  |   | Certifica                          | te of L               | Jeatn            |               | 0.0                             | Reg. No    | . 2011                       | J             | 17987                               |
|                            | Physicia<br>Medic  |                  | Bessie   | G.   |   | Hami                               | 1ton                  |                  |               | 2. Date of De<br>Month<br>April |            | y 2010                       |               | 3. Time of Death 9:52A <sup>M</sup> |
|                            | Examir   | er               | 4a. Facility Name (if not institution  | . 5  | )   |                                    |                       | r Location       | of Death      |                                 | 1 .        | . County of Dea              | -             | 1                                   |
|                            | <u></u>  |                  | 165 Barbara  5. Social Security Number   |  | Age (In yrs. last birth                         |                                    | erna<br>er 1 Year     | Park<br>If Under | 24 Hre        | 9 Date of Bir                   |            | nne Aru                      | م دا مرافد    | o Casa ou Francisco                 |
|                            | Funeral<br>Director  |                  | 231-03-5492  | 1 □ M 2  F   |   | Yrs. Months                        |                       | Hours            | Min.          | 8. Date of Bir<br>Oct. I        | Year)      | 19                           | ntnpiad       | e (State or Foreign<br>Virgina      |
|                            |  |                  | Usual Residence of Decedent  |  |   |                                    |                       |                  |               |                                 |            |                              |               |                                     |
|                            | /land<br>f sho<br>od at  | to               | 10a. State 10b. County   |  | 10c. City, Town                                 | or Location                        |                       |                  |               |                                 |            |                              | 10d.          | Inside City Limits                  |
|                            | Mar.<br>28a-<br>otifie   | je               |  | Arunde1  | Seve  | rna Par                            |                       |                  |               |                                 |            |                              |               | 1 Yes 2 No                          |
|                            | th the   | Funeral Director | 10e. Street and Number   |  |   |                                    | ip Code               |                  |               |                                 | _          | tizen of What C              | ountry'       | ?                                   |
|                            | ms 2<br>mus  | ] Je             | 165 Barbara R  | 12. Was Deceden                                      | A Francis III C                                 | _                                  | 146                   | inneria Ori      | -i-0 (C       | -16 - V N-                      | U.S        |                              |               |                                     |
| <b></b>                    | or dea   | 호<br>교           | <ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>               | Armed Forces   | 32_   | If Yes, sp                         | ecify Cuba            | ın, Mexicar      | n, Puerto F   | cify Yes or No-<br>Rican, etc.) |            | 14. Race - Am-<br>Black, Whi |               |                                     |
| 036                        | s afte<br>ral",  | g pe             | 3  | If Van Oire  |   | 1 🗆 Yes                            | 2 🗓 No                | Specify:         | :             |                                 |            | Specify: Wh                  | ite           | 2                                   |
| 21215-0036                 | within 72 hours after death with the Maryland<br>giene.<br>er than "natural", or items 23a or 28a-f sho<br>the Medical Examiner must be notified at  | Completed by     |  | nt's Education est grade completed)                  |   | Decedent's Us<br>(Give kind of w   |                       |                  | et of working | 22                              | 16b. K     | ind of Business              | Indus         | try                                 |
| 2                          | hin 72<br>Je.<br>Ihan '<br>e Me  | Ē                | Elementary/Seconday (0-12)   | College (1-4 o                                       | r 5+)   | life. DO NOT u                     | se retired)           | ianng mos        | L CI WOIKII   | ig                              |            | II                           |               |                                     |
| 12                         | d with<br>tygien<br>ther t   | BeC              | 17. Father's Name (First, Middle,  | L and)   | noi   | nemaker                            |                       | 40.14.4          | 1.11          |                                 |            | n Home                       |               |                                     |
| Maryland                   | 2 should be filed within 72 h and Mental Hygiene. 77 is marked other than "traumatic event, the Med  | 2                | Charles Hedge  | _asij  |   |                                    |                       | Roxi             |               | (First, Middle,                 | ivialden i | Surname)                     |               |                                     |
| Σ                          | ould<br>mari   |                  | 19a. Informant's Name/Relations  | hip (Type, Print)                                    | 19h   | Mailing Addre                      | ss (Street :          |                  |               |                                 | er City or | Town, State, Z               | in Cod        | e) 21061                            |
|                            | 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at   |                  | Dr. Earl Hamil   | ton/Son  | I   | _                                  |                       |                  |               |                                 | -          | Glen Bu                      |               |                                     |
| Baltimore,                 |  |                  | 20a. Method of Disposition   | 0 🗆 0  |   | Disposition (Na<br>y, crematory or | ame of                | e)               | April         | ate <sub>2.7</sub>              | 20c. Lo    | ocation - City o             | r Town        | , State                             |
| <u>Ë</u>                   | permit. Page 1 Department of Important: If i any injury or once.   |                  | 1 💢 Burial 2 □ Cremation<br>4 □ Donation 5 □ Other (                                 |  |   | Haven M                            |                       | ark              | 201           |                                 | Gle        | n Burni                      | е,            | MD                                  |
| Salt                       | permit. Departi Import any inj once.   |                  | 21. Signature of Funeral Service   | icensee  |   |                                    |                       |                  | _             |                                 |            | ral & C                      |               |                                     |
| _                          | 90 = 8 9   |                  | for al.  | Van  | MO1357  |                                    |                       |                  |               |                                 |            | n Burni                      | е,            | MD 21061                            |
|                            |  |                  | 23a. Part 1. Enter the disease, or shock, should be illure. List                     | only one cause on each li                            | ne.   |                                    |                       |                  |               |                                 |            |                              | Int           | oproximate<br>terval Between        |
|                            | Physician/<br>Medical  |                  | Immediate Cause (Final disease or condition resulting in death)                      | ARTEN  | s a consequence o                               | BOTTIC                             | CA                    | RPU              | OVA           | SCULAN                          | 2          |                              | OI            | nset and Death                      |
| 4                          | Examiner   |                  | rodding in doddin  | Due to (or a   | s a consequence o                               | f):                                |                       |                  |               | DISE                            | Y13 E      |                              |               |                                     |
|                            |  | Jer              | Sequentially list conditions, if any, leading to immediate                           | b. Due to (or a                                      | s a consequence o                               | f):                                |                       |                  |               |                                 |            |                              |               |                                     |
|                            | ited<br>d<br>ansit   | Examiner         | if any, leading to immediate<br>cause. Enter Underlying<br>Cause (Disease or iinjury |  | ·   |                                    |                       |                  |               |                                 |            |                              |               |                                     |
|                            | ate be executed<br>physician and<br>the burial-transit   | Ë                | that initiated events<br>resulting in death) Last                                    | Due to (or a   | s a consequence o                               | f):                                |                       |                  |               |                                 |            |                              |               |                                     |
| 09                         | te be<br>nysicia<br>ne bur   | edical           |  | d  |   |                                    |                       |                  |               |                                 |            |                              |               |                                     |
| 87                         | rtificar<br>ing ph<br>e as th  | Me               | IF FEMALE:   |  |   |                                    |                       |                  |               |                                 | -1         |                              |               |                                     |
| Box 687                    | ath certific<br>attending p  | Physician/M      | 23b. Was decedent pregnant in the past 12 months?                                    |  | n 2 🗌 Fetal death                               |                                    |                       | ;y               |               |                                 | 1          | 23d. Date of de<br>Month     | elivery<br>Da | y Year                              |
| ğ                          | t the dea<br>by the a<br>tached f  | ysic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9 Unknown  | at time of death                                | 5 Other (                          | вресіту) <sub>—</sub> |                  |               |                                 |            | WOTH                         | Da            | y rou                               |
| P.O.                       | hat th<br>ed by<br>detac   |                  | Part II. Other significant condition   | ons contributing to death                            | but not resulting in                            | the underlying                     | cause giv             | en in Part       | i.            | 23e. Did to                     | obacco u   | ise contribute to            | o the c       | ause of death?                      |
| S,                         | uires th   | q p              | DEMENTIC   | <u> </u>   |   |                                    |                       |                  |               | 1 🗆                             | Yes 2      | □ No 3 □ F                   | robab         | ly 4 🗗 Unknown                      |
| ord                        | v require<br>s been s<br>should  | Completed by     |  |  |   |                                    |                       |                  |               | 24a. Was                        |            |                              |               | findings available                  |
| 3ec                        | The law<br>ate has<br>page 2 :   | E O              |  |  |   |                                    |                       |                  |               | autor<br>perfo                  | ormed?     | death?                       |               | etion of cause of                   |
| alF                        | i <b>cian:</b> The<br>certificate<br>ector, pag  | Be C             | 25. Was case referred to medical examiner?   |  |   |                                    | 26. Pl                | ace of Dea       | th (Check     |                                 | 2 42 190   | <u> </u>                     | 3 2 5         |                                     |
| ₹                          | Physician:<br>this certific<br>al director,  | 2                | 1 Yes 2 No   | Hospital:  | atient 2 ER/Out                                 | patient 3 🗆 [                      | Othe                  | er:<br>4 🗌 Nt    | ursing Hor    | ne_5 Resid                      | dence 6    | Other (Spec                  | cify)         |                                     |
| Jo (                       | ing P  | ate:             | 27. Manner of Death 1 ☑ Natural 5 ☐ Pendir   | 28a. Date of in<br>(Month, D                         | ijury 28b. Ti<br>Day, Year) in                  | jury                               | 28c. Injury<br>work   | ?                |               | 8d. Describe h                  | now injury | y occurred                   |               |                                     |
| ioi                        | r Attending Phy<br>ter death.<br>rector: After this<br>by the funeral o  | Certificate:     | 2 Accident Investi 3 Suicide 6 Could   | gation<br>not be                                     | - At home for                                   | M                                  |                       | Yes 2            | _             |                                 |            |                              |               |                                     |
| Division of Vital Records, | I or Atten<br>after deat<br>Director:<br>I in by the   | Cer              | 4  Homicide determ   | ined 286. Place of Ir<br>building, 6                 | njury - At home, fan<br>etc. (Spec <i>ify</i> ) | n, street, tacto                   | ry, oπice             |                  | 2             | 28f. Location (S<br>City or Tou |            | d Number or Ru               | iral Ro       | ute Number,                         |
|                            | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.  Of the Funeral Director. Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi | ical             | 29a. Certifier 1 Certifying  | Physician: To the best of                            | of my knowledge, d                              | eath occured a                     | t the time            | date and         | place, and    | I due to the ca                 | iuse(s) an | d manner as st               | ated.         |                                     |
|                            | ne Ho<br>in 24 I<br>ne Fui<br>pletec   | Medical          | (Check 2 $\sqsubseteq$ Medical L   | xaminer: On the basis of<br>Nurse Practioner: To the | examination and/or                              | investigation, in                  | n my opinic           | n, death oc      | ccurred at    | the time, date a                | and place, | , and due to the             | cause(        | s) and manner stated.               |
|                            | To the I within 2 To the I comple  | _                | 29b. Signature and title of certifie   |  |   | 29                                 | c. License            | number           | _             |                                 | 29d. Dat   | te signed (Mont              | h, Day,       | Year)                               |
|                            |  |                  | -0.00  | WE M   | シ   |                                    | 12                    | 1779             |               | /                               | MRI        | L 23,                        | 20            | 010                                 |
|                            |  |                  | 30. Name and address of person $SUPUAP$ . $M$  |  | death (Item 23a) (T                             | ype, Print)                        | 121                   | n. Pr            | 1 00          | - B1                            | 271        | mole                         | -             | 21225—                              |
|                            | Sta  | _                | 31. Date filed (Month, Day Year)   | 32. Regis  | trans Signature                                 | 00                                 | ,                     |                  |               | ,                               |            | ,                            | -             | - 3                                 |
|                            | Sta  | v                | ADD 2.7 2010   | (busine  | a. wan  | -                                  |                       |                  |               |                                 |            |                              |               |                                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hunt, Jr. 4.05 PM Stephen Warren Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Bel Air Upper Chesapeake Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F March I7, 86 189-12-8311 1924 Nebraska **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Harford Forest Hill Md. 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21050 USA 1700 Rich Way Unit 1A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces by X Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) BGE +4 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic ever ည Leona Pattison Stephen Warren Hunt, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Rich Way Unit 1A Forest Hill, Md. 21050 Mrs. Virginia R. Hunt/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Qulaney Valley Mem. 4-27-10 Timonium, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Fureral Service Licenses York Rd. Towson, Md. Part 1. Enter the disease, it complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) emo Due to (or as a consequence of) attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be CONCINOTIO auanaIF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day 1 Yes 2 9 Unknown Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Appatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certif D0053568 140, 500 upper Chesapeak 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

I HOMPSON

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Apri Physician/ 2010 3:15 A M 6 Mary L. Hammock Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice g. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Maryland 1 □ M 2 🔽 1922 Director 219-18-0642 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any ijury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21227 USA 4610 Ridge Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married ☐ Yes 2X No Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Specify: 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-employed 12 4 P<u>iano Teacher</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Flora Frank Victor Slifer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3324 Goodley Road, Garnet Valley, PA 19060 Richard Hammock / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4/27/2010 Bavview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. . Ingrature of Funeral Service Licens 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ TROKE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SPONTANEOUS PNEUMOTHORAK 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? CORONADY ARTERY 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death

20

Registrar

Medical

29a. Certifier

only one 29b. Signature and title of cer

PANIEUE 31. Date filed (Month, Day, Year)

3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBELMANI MO

32.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D64395

670/ NCHAPLES ST, SUITE 4105 BALTIMITEIMD 21204

APRIL 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Bertha Hickman APril 23, 2010 11:25p <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heritage Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 8 / 4 / 1933 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 1 □ M 2 🛣 F Yrs Director 76 218-28-1676 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Evaminar must be redified at Director 1 Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1232 Cleveland Street Funeral 21230 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker 0 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry F. Hall Elise I. Hagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 Red Maple Lane, Harper's Ferry, WV 25425 Betty Staubs / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Pk. 4/27/2010 Middle River, Maryland 2. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Mayryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition as ESPRATORY FAILURE

a. RESPRATORY Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially not conunious, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trai Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) hed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □ Yes 1 ☐Yes 2 ☑No 2 No Be 25. Was case referred to medical examiner? 26. Place or Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manne f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 L Matural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 D'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Hospital or Attending Physician: completely filled in by e Funeral I To the I within 2

State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

le Tulle Mo

Marle

Deudalu M1) 21222

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 23, 2010 MARTIN S HIMELES, SR. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M M 2 □ F Months Days Hours Min. 12/23/1923 86 Director 490-22-7138 Yrs. Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County Director or 28a-f si notified PALM BEACH FL PALM BEACH ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be 200 BRADLEY PLACE, #306 33480 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Armed Forces? 1 M Yes 2 □ No If Yes, Give ٩. ò 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify "natural" 3 Divorced Completed Year or Dates Ith and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 **BUSINESS OWNER** MEDICAL IMAGING Be permit. Page 1 and 2 should be filed. Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL HIMELES CHARLOTTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 STONE MILL ROAD, BALTIMORE, MD BETTY HIMELES/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. : 4/25/2010 | REISTERSTOWN, MD 21. Signature of Furreral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a, Part 1, Enter the disease, or co fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ MOUR Medical Due to (or as a consequence of): Examiner Areim Sequentially list conditions, if any leading to be recipitate cause. Enter Underlying Examiner sician and burial-transit Cause (Disease or iinjury armory artery du that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed

23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 X 1 Yes 2 No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3. Time of Death

Αм

7:25

Birthplace (State or Foreign Country)

Race - American Indian,

WHITE

Black, White, et

WEISS

10d. Inside City Limits

Approximate Interval Between

Inset and Death

1 ☐ Yes 2 🛣 No

Division of Vital Records, P.O. Box 68760 ate has been signed by the a page 2 should be detached it Hospital or Attending Physician: 24 hours after death. Funeral Director: After filled in by the

Be

ဂ္

25. Was case referred to medical

2 No

5 Pending

Investigation

6 Could not be

examiner? 1 Yes

27. Manner of Deal

1 Natural

Accident

Certificate: 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🚧 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifier 29b. Signature who completed cause of death (Item 23a) (Type, Print) 1188 31. Date filed (Month, Day, Year, State Registrar

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28a. Date of injury (Month, Day, Year)

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                            |  |                  | For State Registrar   | State of Maryland /   | Department of Health ar<br>Certificate of Death   |   |                                    |  |
|----------------------------|--|------------------|---|---|---|---|------------------------------------|--|
|                            | Physici  | an/              | 1. Decedent's Name (First, Middle, La   | - r   | oor modelo or Dodin   | 2. Date of Death                          | Nº2010                             | 3. Time of Death                                   |
| - 1                        | Med  | cal              | Joseph -  | Janifer   |   | 4 3                                       | Day Year <b>20:0</b>               | 1:30 P M   |
|                            | Exami  | ner              | Season's H  | DSDice  | 4b. City, Town, or Location of D  | 5 Wn                                      | 4c. County of Deat                 | imore  |
|                            | Funera   |                  | 5. Social Security Number 6. S  | Sex 7. Age (In yrs. last bin  | thday) If Under 1 Year If Under 24  |   | 9. Birt                            | hplace (State or Foreign                           |
|                            | Director   |                  | Usual Residence of Decedent   |   | Yrs. World's Days Hours   | 2-16-19                                   | 734                                | MIND   |
|                            | with the Maryland<br>23a or 28a-f sho<br>ust be notified at  | ctor             | 10a. State 10b. County  | 10c. City, Tow  |   |   |                                    | 10d. Inside City Limits                            |
|                            | the Ma<br>or 28a<br>e notifi   | Dire             | 10e. Street and Number  | more Kana   | 10f. Zip Code   | 10g.                                      | Citizen of What Co                 | 1 Yes 2 No   |
|                            | th with<br>ns 23a<br>nust b  | Funeral Director | 3847 Elmer  | oft Road  | 21/33   |   | USA                                |  |
| ယ                          | 72 hours after death<br>n "natural", or items<br>ledical Examiner m  | by Fu            | 11. Marital Status  1 Never Married 2 Married                                     | 12. Was Decedent Ever in U.S. Armer Forces? 1 ☑ Yes 2 ☐ No          | 13. Was Decedent of Hispanic Origin<br>If Yes, specify Cuban Mexican, Po  | (Specify Yes or No-<br>uerto Rican, etc.) | 14. Race - Amer<br>Black, White    |  |
| 003                        | urs aft<br>tural",<br>al Exal  | ted t            | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates. 1953                                 | 1 ☐ Yes 2 ☑No Specify:  |   | Specify: 8                         | ack  |
| 21215-0036                 | 72 ho<br>an "na<br>Medica  | Completed        | 15. Decedent's E<br>(Specify only highest gr                                      | ade completed)  | Decedent's Usual Occupation (Give kind of work done during most of  | working 16b                               | . Kind of Business I               | ndustry  |
|                            | yglene.<br>her thar<br>nt, the M   | Be Co            | Elementary/Seconday (0-12)  | College (1-4 or 5+)   | 1) 1 / 1  | ager 6                                    | 15 PS                              |  |
| and                        | ild be filed<br>Mental Hy<br>harked oth  | To B             | 17. Father's Name (First, Middle, Last)   | ani fer   | 18. Mother's  | 7   |                                    |  |
| Maryland                   | should and is in   |                  | 19a. Informant's Name/Relationship (7   |   | . Mailing Address (Street and Number or   | 7   | <b>NGSC</b><br>or Town, State, Zip | Code)  |
|                            | 1 and 2 s<br>of Health<br>item 27<br>other tra   |                  | Mildred Jan  20a, Method of Disposition   | iter/Wite 3   | 847 Elmcroft  | Road Rai                                  | nda 11st                           | ما با 🕰 جدما                                       |
| Baltimore,                 | permit. Page 1 a Department of I Important: If its any injury or of  |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci                        | Removal from State  | f Disposition (Name of<br>ry, crematory or other place)   | Date 20c.                                 | Location - City or                 |  |
| altin                      | permit. Page<br>Department<br>Important: I<br>any injury o   |                  | 21. Signature of Funeral Service Licens   | - Oli Ci  |   | auchn C. 90                               |                                    | ND<br>neral Services                               |
| 8                          | 20 E 20 P  |                  | Vancher C.  | Grune   | 8728 Liberty  |   | Ulstonn,                           | mu 21/33   |
| B                          | Physician/   |                  | shock, or heart failure. List only o<br>Immediate Cause (Final                    | ne cause on each line.  | ot enter the mode of dying, such as care<br>ic lung cancer  | diac or respiratory arrest,               |                                    | Approximate<br>Interval Between<br>Onset and Death |
|                            | Medical  |                  | disease or condition resulting in death)  | a. Due to (or as a consequence of                                   | - W   |   |                                    | Chock and Board                                    |
| B                          | Examiner   | ē                | Sequentially list conditions,   | b. —  |   |   |                                    |  |
|                            | uted<br>d<br>ansit   | Examiner         | if any, leading to immediate cause. Enter Universitying Cause (Disease or linjury | Due to (or as a consequence of                                      | or):  |   |                                    |  |
|                            | cate be executed<br>physician and<br>s the burial-transit  | al Ex            | that initiated events resulting in death) Last                                    | Due to (or as a consequence of                                      | rf):  |   |                                    |  |
| 760                        | cate be<br>physic  | ledical          |   | d   |   |   |                                    |  |
| 89                         | death certifica  |                  | zezi iras accodent pregnant   | 23c. If yes, outcome of pregnancy<br>1 □ Live Birth 2 □ Fetal death | 3 Ectopic pregnancy   |   | 23d. Date of deliv                 | very   |
| Box                        | 5 9 8  | Physician/N      | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                 | 4 Pregnant at time of death 9 Unknown                               | 5 Other (specify)   |   | Month                              | Day Year   |
| P.O.                       | requires that the de<br>been signed by the<br>should be detached   | by Ph            | Part II. Other significant conditions co  | ontributing to death but not resulting in                           | n the underlying cause given in Part I.   | 23e. Did tobacco                          | use contribute to t                | he cause of death?                                 |
| ds,                        | equires<br>en sign<br>ould be  | ted k            |   |   | ,   | _ 1 ☐ Yes                                 | 2 □ No 3 □ Pro                     | obably 4 D Unknown                                 |
| Division of Vital Records, | has be   | Completed        |   |   |   | 24a. Was an autopsy                       | prior to co                        | opsy findings available ompletion of cause of      |
| E E                        | Physician: The law<br>this certificate has<br>al director, page 2 a  |                  | 25. Was case referred to medical  |   | 26. Place of Death (C   | performed?                                |                                    | 2 🗆 No   |
| Vita                       | hysicia<br>nis cer<br>I direct   | To Be            | examiner?<br>1  Yes 2  No   | Hospital:<br>1 ☐ Inpatient 2 ☐ ER/Out                               |   | Home 5 Residence                          | 6 Other (Specifi                   | p-patient hospice                                  |
| n of                       | ding P<br>h.<br>After ti<br>funera   | ate:             | 27. Manner of Death  1 Natural 5 □ Pending  | 28a. Date of injury (Month, Day, Year) 28b. Ti                      | ime of 28c. Injury at jury work?  | 28d. Describe how inju                    | ury occurred                       |  |
| isio                       | Atten<br>er deat<br>ector:<br>by the   | Certificate:     | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined           | 28e. Place of Injury - At home, far                                 | M 1 ☐ Yes 2 ☐ No<br>m, street, factory, office  | 28f. Location (Street a                   | and Number or Rura                 | l Route Number.                                    |
| Ω                          | oital or<br>urs aftu<br>ral Dir  | <u>8</u>         |   | building, etc. (Specify)  |   | City or Town, Stat                        | te)                                |  |
|                            | To the Hospital or Attending Physician: The law requires that the wintin 24 hours after death.  To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. | Medical          | (Check 2 L. Medical Exami   | <b>ier:</b> On the basis of examination and/or                      | leath occured at the time, date and place<br>investigation, in my opinion, death occurred<br>edge, death occurred at the time, date and | ed at the time date and place             | o and due to the or                | uso(a) and manner stated                           |
|                            | Vithir Comp  |                  | 29b. Signature and title of certifier hs  |   | 29c. License number  D 005 7 46   | 20d D                                     | ate signed (Month,                 | Day, Year)   |
|                            |  |                  |   |   |   |   | 4/22/                              |  |
|                            |  |                  | N.S. RyapaKs  | e, M.D., 2835 S   | ype, Print) Av. 5-203,  | Baltimor                                  | e, MD, 2                           | 1209   |
|                            | Stat<br>Registra   | e                | 31. Date filed (Month, Day, Year) APR 27 201                                      | 32 Registrar's Signature  | 1.01  |   |                                    |  |
|                            |  | 00               | 7111 61 201   | U KREWN B. 4  | Barre   |   |                                    |  |

DHMH 17 Rev 7/2009

|                            |   |                         | 1 - For<br>State<br>Registrar   | State of Ma  | aryland / Dep<br><i>Ce</i>          | artment of F<br>ertificate of                             |  |  | giene<br>Reg. No.2                             | 12988   |
|----------------------------|---|-------------------------|---|--|-------------------------------------|---|--|--|--|---|
| ass                        | Physic  | ian                     | 1. Decedent's Name (First, Middle L) LLIAN  | JON  | ICC                                 |   | - "  | 2. Date of Dea<br>Month                    | th<br>Day Year                                 | 3. Time of Death                                    |
|                            | /Medi<br>Examii   |                         | 4a. Facility Name (If not institution   | , give street and number)  |                                     | 4b. City, Town, o   | r Location of Death                                      | 09   | 4c. County of Dea                              |   |
|                            |   | e Service.              | MAGNOUA  5. Social Security Number  | NURSING  | HOME                                |   | anham  |  |  | George's  |
|                            | Funeral<br>Director   |                         | 236-40-8080 Usual Residence of Decedent   | 6. Sex 7. Ag   | e (In yrs. last birthday<br>85 Yrs. | Months Days   | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth<br>(Month, Day<br>April 4 | , 1925 Wes                                     | rthplace (State or Foreign<br>ountry)<br>t Virginia |
|                            | yland<br>now<br>at  |                         | 10a. State 10b. County  |  | 10c. City, Town or L                | ocation   |  |  |  | 10d. Inside City Limits                             |
|                            | e Mar<br>Ba-f st<br>stiffed   | ctor                    |   | e George's   |                                     | Lanha   | m  |  |  | 1X Yes 2 □ No                                       |
|                            | ath with the 23a or 2 ust be no   | <b>Funeral Director</b> | 10e. Street and Number<br>8200 Good Luc   | k Road   |                                     | 10f. Zip Code<br>20                                       | 706  |  | 10g. Citizen of What C<br>US                   | ,   |
| 9600                       | be filed within 72 hours after death with the Maryland nat Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | b                       | 11. Marital Status  1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:   | Ever in U.S. 13.                    | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 No | lispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)           |  |   |
| Maryland 21215-0036        | vithin 72 h<br>ne.<br>han "natu<br>e Medica   | Completed               | 15. Decedent<br>(Specify only highes<br>Elementary/Secondary (0-12)   | 's Education<br>st grade completed)  College (1-4or 5                    | (Give                               | DO NOT use retired  | during most of worki                                     | ing  | 16b. Kind of Business                          | Industry  |
| d 2                        | filed<br>Hygi<br>ther<br>int, t   |                         | 12th 17. Father's Name (First, Middle,  | Last)  |                                     | Clerk   | 18. Mother's Name  | (First, Middle,                            | Governi<br>Maiden Surname)                     | ment  |
| /lan                       | should be filed<br>and Mental Hyg<br>s marked other<br>umatic event, I  | To Be                   | John W. H   | arris  |                                     |   |  | lia Col                                    | ,  |   |
| Man                        | S 8 8   |                         | 19a. Informant's Name/Relationsh  |  |                                     |   |  |  | r, City or Town, State,                        |   |
|                            | s 1 and 2<br>f Health<br>item 27  |                         | Deannette A. Ha 20a. Method of Disposition  |  | 20b. Place of Disp                  | osition (Name of  |  |  | irfax, VA 2                                    |   |
| imo                        | Pages<br>nent of<br>ant: If it  |                         | 14 Bunal 2 □ Cremation<br>4 □ Donation 5 □ Other (Sp  |  |                                     | matory or other plac<br>n Nationa                         | , i  | 2010                                       | Arlington                                      | , Virginia  |
| Baltimore,                 | permit. Pages<br>Department of<br>Important: If it<br>any injury or once.   |                         | 21. Signature of Funeral Service I  | Licensee   |                                     |   |  | timore I                                   | Tuneral Sei<br>am, Marylar                     | vices, P.A.   |
| a way                      | Physician   |                         | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition                       | complications that caused only one cause on each lir                     |                                     | ter the mode of dyin                                      |  | or respiratory arr                         | est,   | Approximate<br>Interval Between<br>Onset and Death  |
| -                          | /Medical<br>Examiner  |                         | resulting in death)   | Due to (or as  | a consequence of):                  |   |  |  |  | UNKNOWN   |
| J.                         |   | iner                    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b<br>Due to (or as   | a consequence of):                  |   |  |  |  | UNKNOWN<br>UNKNOWN<br>UNKNOWN                       |
| ,                          | execute<br>and  | Examiner                | that initiated events<br>resulting in death) Last   | c. Due to (or as   | a consequence of):                  | MELLITI   | 15   |  |  | UNIENOWN  |
| 68760,                     | ifficate be executed<br>g physician and<br>as the burial-transit  | edical 8                |   | d. CEREBI  | a consequence of):  VASCU           | LAR A   | +CCIDEN  | π  |  | UNKNOWN   |
| P.O. Box (                 | attendin<br>for use   | Physician/Me            | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 poinths?<br>1 ☐ Yes 2 154 No<br>9 ☐ Unknown                            | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown  | 2 ☐ Fetal death 3[                  | □Ectopic pregnancy<br>□ Other (specify)                   |  |  | 23d. Date of de<br>Month                       | livery<br>Day Year                                  |
|                            | w requires that the de<br>been signed by the<br>should be detached  | by                      | Part II. Other significant conditio   | ns contributing to death bu  | ıt not resulting in the ι           | inderlying cause give                                     | en in Part I.  |  | pacco use contribute to                        | o the cause of death?                               |
| Division or Vital Records, | The law<br>ate has b<br>page 2 s  | Completed               |   |  |                                     |   | -  | 24a. Was a<br>autops<br>perfori<br>1∐ Yes  | by prior to                                    | utopsy findings available completion of cause of    |
| Zi.                        | Physician: The this certificate ral director, pag   | o Be                    | 25. Was case referred to medical examiner?  1 \( \text{Yes} \) Yes  | Hospital:  | nt 2∏ER/Outpatie                    | nt 3□ DOA Othe  | 26. Place of Death                                       |  |  |   |
| n or                       | ng Phy<br>fter thi  | n: To                   | 27. Manner of Death Natural 5 ☐ Pending   | 28a. Date of Injur   | y 28b. Time o                       | of 28c. Injury  | y at   | ne 5∟Reside<br>28d. Describe ho            | ence 6 □Other (Spe                             | ecify)  |
| Sio                        | Attending r death. ector: After by the fune   | catic                   | 2 Accident investig   | ation  |                                     | M 1 □   | Yes 2 No   |  |  |   |
| Div                        | ital or A<br>rrs after or<br>ral Direct<br>lled in by   | Certification:          | 4 ☐ Homicide determin   | building, etc  |                                     |   |  | City or Town                               |  |   |
|                            | To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.                       | Medical                 | one) 2 Medical E  | Physician: To the best of<br>Examiner: On the basis of<br>and manner sta | examination and/or in               | h occurred at the tin<br>vestigation, in my o             | ne, date and place, a<br>pinion, death occurr            | and due to the c<br>ed at the time, d      | ause(s) and manner a<br>late and place, and du | s stated.<br>e to the cause(s)                      |
|                            | To the within 2 To the complei  | 2                       | 29b. Signature and title of certifler   | - M:   | D                                   | 29c. License  |  | 2  | 9d. Date signed (Moni                          | h, Day, Year)                                       |
|                            |   | -                       | 30. Name and address of person v  | ·  |                                     | Print)  | 63978<br>LANHA   |  | 7/26/  | 4010  |
|                            |   |                         | MINA SYGO,  | 1 8200 (   | SOOD LIKE                           | e Ros   | LANHA  | m,   | MD   |   |
|                            | Sta<br>Registr  | te<br>ar                | 30. Name and address of person v  | 27 2010 Register   | rs Signature                        | pare  |  |  |  |   |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month APRIL ESSIE JONES 1406 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/15/1917 Age (In yrs. last birthday) Months 1 □ M 2X F 233-40-9710 92 Maryland Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 329 S. Ann Street 21231 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 XNo 1 ☐ Yes 2 🛣No If Yes, Give Year or Dates: Specify White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Machine Operator Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Stull Cora E. Janice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Snyder - Son 329 S. Ann Street Baltimore, Maryland 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) MeadOwridge 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/29/2010 Elkridge, Maryland 4 Donation 5 Other (Specify) Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Lice David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATORY disease or condition resulting in death) Due to (or as a consequence of) PNEUMONIA Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Divisito (or asi a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 XNo 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 $\square$ Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

**Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after death.

I Director: A
d in by the f

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

**Funeral** 

**Director** 

notified

must be

the Medical Examiner

event,

traumatic

item 2

permit. Pages Department of Important: If it any Injury or o

**Physician** 

/Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. soft Health and Mental Hygiene. attems 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

25. Was case referred to medical 1 ☐ Yes 2 🔀 No 28a. Date of Injury
(Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending investigation Injury 2 Accident 1 Tes 2 □ No 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

RE( - 000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

APRIL 29 2040

State Registrar

filled in 24 hours

completely

within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOBIND 31. Date filed (Month, Day, Year)

32. Registrar's Signature

| Susan Nelson Jone | s |  |
|-------------------|---|--|
|-------------------|---|--|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day April 12, 2010 Susan Nelson Jones **Medical Examiner** 1615 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13001 Twin Brook Rockville Montgomery 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 578-62-9037 Country Director Months 2 X F 11/15/1946 M 63 Michigan Usual Residence of Decedent any 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits MD s 23a or 28a-f shov e notified at once. Montgomery Rockville 1 Yes 2 X No death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13001 Twin Brook Pkwy 20851 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes after 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry peted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ages 1 and 2 should be filed within 72 hant of Health and Mental Hygiene.

11: If item 27 is marked other than "1 other traumatic event, the Medical E College (1-4 or 5+) Baltimore, MD 21215-0036 5+ Ret. Federal Employee Federal Government 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert Nelson Jones Dorothy Louise McGuiness Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Jones Thorum/Sister 593 Holly Haven Rd. Weems, VA 22576 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem LLC 04/21/2010 Glen Burnie MD Donation 5 Other Specify: 22. Name and Address of Facility Simplicity Crem & Phomas Allen P.A. 7090Ridge Rd 21. Signature of Funeral Service Licens Fun Serv HanoverMD Thomas Allen P.A. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) tause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical : attending physician for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✓ Yes 2 No 1 🗸 Yes Hospital or Atteoding Physiciao: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Autonomic within 24 hours after death.

To the Funeral Director: A Certification 1 V Natural Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 13, 2010 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Pay, X

State

32. F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Katherine Marie Johnson 23, April 2010 4:00P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 12 1 Months Days Hours Director 215-34-9506 April 6, 1938 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Directo 1 □Yes 2 No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 'natural", or items 23a 501 Summit Drive 21047 Pages 1 and 2 should be filed within 72 hours after death v nent of Heatth and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23. Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify. 3√Widowed 4 □ Divorced Specify: White er than "natura , the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James William Goff, Sr. 2 Winifred Cain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Cruise / Sister 186 Beaver Street E. Berlin, Pennsylvania 17316 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel April 24, Bel Air Forest Hill, Maryland 2010 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland OX 23a. Part 1. Enter the disease, or complements that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only in cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) anding physician a use as the burial-Due to (or as a consequence of) Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months: Month Day Year 5 Other (specify) o. ☐Yes 2 ☐No 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate I performed' 1 □ Yes 2 40 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Hnpatient Division of After this Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manne Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

525414

Katherine

Johnson,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Nesreen Kurtom 31. Date filed (Month, Day, Year)

APR 27

H0062765

500 Upper Chesapeake Drive Bel Air, Maryland 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| lelody Hamber  |              | 1- For State   | e of Marylan                              |                   | artment of                              |                       |            | Mental                           | i Hyg           | iene                           | Reg. N                    | 201                            | 0                               | 1,2                        | 992                               |
|--|--------------|--|---|-------------------|---|-----------------------|------------|----------------------------------|-----------------|--------------------------------|---------------------------|--------------------------------|---------------------------------|----------------------------|-----------------------------------|
| Physicia<br>Medical Exami  | an/          | Registrar  1. Decedent's Name (First, Middle, L Melody                                   | ast)                                      |                   |   | effe                  |            | า                                |                 | Date of D<br>Month<br>April 17 | eath<br>Day               | v Year                         | 3                               | 3. Time of I               |                                   |
|  |              | 4a. Facility Name (if not institution, g<br>Johns Hopkins Hospital                       | give street and numb                      | per)              | 41                                      | o. City, To<br>Baltim |            | ocation of D                     |                 |                                |                           | 4c. County of                  | Death                           |                            |                                   |
| Funeral<br>Director  |              | 5. Social Security Number 6.   |   | Age (In yrs, I    |   | If Under<br>Months    |            | If Under 24<br>Hours             | Min.            |                                |                           | M/DD/YYYY)                     | 9. Birth<br>Foreign<br>Coun     |                            | e or<br>M.D.                      |
|  |              | Usual Residence of Decedent  | M 2KF                                     | 2                 | Yrs.                                    |                       |            |                                  |                 | 11                             | 07                        | 2007                           |                                 |                            | City Limits                       |
| Aaryland<br>28a-f show any<br><u>1 at once,</u>  | ١            | 10a. State 10b. County NA  | Ą   |                   | altimo                                  |                       |            |                                  |                 |                                |                           |                                |                                 |                            | 2 No                              |
| ith the Maryland<br>23a or 28a-f shov<br>notified at once.   | Director     | 10e. Street and Number   |   |                   |   | 10f. Zip (            |            |                                  |                 |                                | 10g. C                    | citizen of What                |                                 | -                          |                                   |
| with the<br>18 23a o<br>19 notifi  | ra D         | 4002 Ayrdale A   | 12. Was Deced                             |                   | .s. 13. Was                             | Deceden               | t of Hispa | 215<br>anic Origin?              | ( Speci         | fy Yes or                      | No-                       | U . S                          | America                         |                            | Black,                            |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  | / Funeral    | 1 Never Married 2 Married 3 Widowed 4 Divorce  | ed Armed Force 1 Yes ed If Yes, Give Year | es?<br>2 🗽 No     |   | s, specity<br>Yes 2.  |            | vlexican, Pu<br>s <i>pecify:</i> | јепо кіс        | can, etc.)                     |                           | White,                         | <sub>вкс.</sub><br>В <b>1</b> а | ck                         |                                   |
| hours a<br>natural<br>Examin   | ted by       | 15. Decedent's Education (Specify Elementary/Secondary (0-12)                            | only highest grade                        |                   | 16a. Decedent'<br>during mo             |                       |            | n (Give kind<br>O NOT use        |                 |                                | 16b                       | . Kind of Busi                 | ness/Ind                        | dustry                     |                                   |
| 036<br>Athin 72<br>Ene.<br>or than '   | ompleted     | N/A  | N/A                                       | u 5.,             |   | N/A                   |            |                                  |                 |                                |                           | N/A                            |                                 |                            |                                   |
| 215-0036 be filed within 7 mal Hygiene. rrked other than   | Be Co        | 17. Father's Name (First, Middle, La  Tyrone Hamber                                      |   |                   |   |                       |            | .Mother's N<br>Keya              | •               |                                |                           | en Surname)                    |                                 |                            |                                   |
| 212<br>should b<br>and Ment<br>is mark   | 10           | 19a. Informant's Name/Relationship   | (Type, Print)                             |                   |   |                       | (Street a  | and Number                       | r or Rura       | al Route N                     | umber,                    | City or Town,                  |                                 |                            |                                   |
| e, MD<br>I and 2 sho<br>Health and<br>item 27 is   |              | Keyaira Jeffer   |   | 20b. l            | Place of Disposit<br>crematory or other | ion (Name             |            |                                  |                 | alli                           |                           | c. Location - C                |                                 |                            |                                   |
| Baltimore, permit. Pages l ar Department of Hee Important: If ite  |              | Burial 2 Cremation  Donation 5 Other Speci   | ify:                                      | State             | ng Mem                                  | oria                  | 1 P        | ark                              | 4/2             | 2/20                           | 10                        | Woodl                          | awr                             | n, Mo                      | <u> </u>                          |
| Balt<br>permit<br>Depart<br>Impor<br>injury  |              | 21. Signature of Funeral Service Lic   | JAMAN                                     | /                 | 43                                      | 00 V                  | laba       | f Facility<br>Wes<br>sh A        | ve,             | Bal                            | tin                       | nore,                          | Mđ                              |                            |                                   |
| Physician<br>/Medical  |              | 23a. Part I. Enter the disease, or contailure. List only one cause on                    |   |                   | . Do not enter the                      | e mode of             | dying, su  | ich as cardi                     | iac or re       | spiratory                      | arrest, s                 | shock, or heart                |                                 | Between                    | ate Interval<br>Onset and<br>eath |
| Examiner   |              | பூள்nediate Cause (Final disease<br>or condition resulting in death)                     | Due to (or as a co                        |                   | f):                                     |                       |            |                                  |                 |                                |                           |                                |                                 |                            |                                   |
|  | iner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a co                        | onsequence o      | f):                                     |                       |            |                                  |                 |                                |                           |                                |                                 |                            |                                   |
| ited<br>d<br>ansit   | Examin       | (Disease or injury that initiated events resulting in death) Last                        | Due to (or as a co                        | onsequence o      | f):                                     |                       | _          |                                  |                 |                                |                           |                                |                                 |                            |                                   |
| be executed ician and urial - trans  | dical        |  | V AMENDED                                 | noted             | per ME                                  | G902                  | 4/2        | 7/10                             | TT              |                                |                           |                                |                                 |                            |                                   |
| Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fumeral director, page 2 should be detached for use as the burial - transit | ian/Me       | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?                       | 23c. If yes, out                          |                   | 2 Feta                                  | al death              |            | Ectopic pr                       | egnancy         | /                              | 2                         | 23d. Date of de<br>Month       | elivery<br>Da                   | у                          | Year                              |
| Box 6<br>e death cer<br>the attendi  | Physici      | 1 Yes 2 No 9 Unkno   | wn g Unknowr                              | 1                 | 5 Om                                    | er (Speci             |            |                                  |                 | I oo n                         |                           | co use contribu                | A- A- A                         |                            | do otho                           |
| ires that the signed by  | þ            | Part II. Other significant condition   | s contributing to de                      | eath but not re   | esulting in the ur                      | dertying              | ause giv   | en in Part I.                    | _               |                                |                           | No 3                           | _                               |                            |                                   |
| Records,  The law require ficate has been si   | Completed    |  |   |                   |   | ,                     |            |                                  | <del></del>     |                                | as an<br>topsy<br>rformed | prie                           |                                 | psy finding<br>npletion of | s available<br>cause of           |
| tal Rec<br>ician: The l<br>certificate l   | e Con        | 25. Was case referred to medical   | T   |                   |   |                       | S.Place o  | f Death (Ch                      | neck only       |                                | s 2                       | No 1                           | ✓ Yes                           | 2                          | No                                |
| Vita<br>hysicia<br>this cer<br>al direct   | To Be        | examiner?<br>1 ✔ Yes 2 No  |   |                   | ER/Outpatient                           |                       |            |                                  |                 | lome 5                         |                           |                                | Other:                          |                            |                                   |
| Division of Vital tal or Attending Physician: rs after death.  al Director: After this certiled in by the funeral director   | ë            | 27. Manner of Death  1 Natural 5 Pending   |   | ay,Year)          | 28b. Time of In<br>FOUND:<br>1645 hrs   | jury 28               |            | at Work?<br>s 2 ✔ No             | le <sub>u</sub> | ibject a                       |                           | injury occurred<br>ed          | 1                               |                            |                                   |
| Divisi<br>pital or Att<br>ours after de<br>reral Direct  | ertificati   | 2 Accident Investig 3 Suicide 6 Could n 4 Homicide                                       | ot be 28e. Place of                       | of Injury - At he | ome, farm, street                       |                       | office bui | lding, etc.                      |                 | or Town                        | , State)                  | t and Number<br>in Street , Ba |                                 |                            | imber, City                       |
| To the Hospi<br>within 24 hou<br>completely fill   | Ö            |  | ician: To the best oner: On the basis of  | f my knowled      | ge, death occurre                       | ed at the t           | ime, date  | and place,                       | , and du        | e to the ca                    | ause(s)<br>te and p       | and manner a                   | s stated                        | cause(s)                   |                                   |
| To t<br>with<br>To t   | Medical      | 29b. Signature and title of certifier  | and manner state                          | ed                |   |                       | License    |                                  |                 |                                |                           | d. Date signed                 |                                 |                            | r)                                |
|  |              | Carol He   | allav                                     |                   |   |                       | O.C.M      | .E.                              |                 |                                | Ap                        | oril 18, 201                   | 0                               |                            |                                   |
|  |              | 30. Name and address of person who Carol Allan, MD Assis                                 | tant Medical Ex                           |                   | 123a)<br>111 Penn S                     | treet, B              | altimor    | e, MD 2                          | 1201            |                                |                           |                                |                                 |                            |                                   |
| S:<br>Regis  | tate<br>trar | 31. Date filed (Month, Day, Year)  | 010 32. (egis                             | strar's Signatu   | 3. par                                  | Kel                   |            |                                  |                 |                                |                           |                                |                                 |                            |                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 avul 20 Catherine Jackson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Keswick Nursing Home Baltimore If Under 1 Year If Under 24 Hrs.

\*\*\*arthe Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2X F 92 bi 212-16-5992 10 1918 ٧A Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4800 Yellowwood Ave 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛮 No Specify. Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> lvr Beautician Shop Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emmanuel Warren Daisy Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Delores Carter-Sister</u> 1028 St. Dunstans Road, Baltimore, Md 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 4/26/2010 Laural, Maryland 22. Name and Address of Facility
March Funeral Home 21. Signature of Funeral Service Licensee 23a. Parti. Enter the file ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filine. List only one cause on each line.

Immediate Cause (Final disease or condition) 4300 Wabash Ave, Baltimsore, Md 21215 Approximate Interval Between Onset and Death Viabetes mellitus, lyre two LARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duw to for as a gonsection of the Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 3 □ Ectopic pregnancy Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? searchal wherefile 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cerbral adenlar 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 26. Place J Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗸 atural 2 Accident

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be none.

Maryland

68760,

Box

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Records,

Division or Vital

Director

Funeral

Completed by

Be

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death with the Maryland

Examine Physician/Medical ģ Completed To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be Certification: To

as been signed by 2 should be detact

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes, 2 No

1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

700W 404 STREET, BALTITICK E. DID 21211

29b. Signature and title of certifier Modelle The Greyn 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THELE THE GREGIES TOON HO

6 Could not be determined

29c. License number D13657

29d. Date signed (Month, Day, Year) april 21, 2010

State Registrar

Medical

31. Date filed (Month, Rap Kar) 7 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Year Month Physician/ abri DYC Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, Examiner Limone Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 04%07, Pay 19 **Funeral** Months Hours 1 M 2 X F 92 189-07-2411 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. notified at Director 1 ☐ Yes 2 🕅 No **BALTIMORE** REISTERSTOWN MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò er than "natural", or items 23a of the Medical Examiner must be Funeral USA 21136 705 COCKEYS MILL ROAD Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2XXNo 1 Never Married 2 Married þ WHITE 1 ☐ Yes 2XXNo Specify: Specify: Baltimore, Maryland 21215-0036 If Yes, Give 3 X Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ntal Hygiene.
ed other than "
event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည is marked SAVANUCK SOPHIE 7FI\_TNSKY HERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trai 5C NEW YORK NY 10014 ROSALIND JOYCE/DAUGHTER CHARLES STREET APT 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🏋 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CEM.04/26/2010 REISTERSTOWN. MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee B900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 rock 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque ce of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Year Month Day in the past 12 months? 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nation 2 ER/Outpatient 3 DOA 2 X No 1 Yes ဂ္ After this 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at 27. Manner of Death Certificate: (Month, Day, Year) injury 5 Pending Natural 1 Yes 2 No Accident within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation ☐ Accider☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Karl Kunze   | 1- For State<br>Registrar  | te of Marylan                                  |                    | ment of<br>ficate of             |   | Mental                         |   | Reg. No. 20                              | 10   2995                       |  |
|--|--|--|--------------------|----------------------------------|---|--------------------------------|---|--|---------------------------------|--|
| Physician/<br>Medical Examiner   |  | ,  |                    |                                  |   |                                | 2. Date of Dea<br>Month                   | Day Year                                 | 3. Time of Death                |  |
| Medical Examiner   | KARL MICHAEL K  4a. Facility Name (if not institution,   |  | nor)               | 14                               | o. City, Town, or Lo                          | nooting of D                   | April 23,                                 | 2010<br>4c. County of                    | 2005 hrs                        |  |
|  | Upper Chesapeake Me  | •  | 501)               |                                  | Bel Air                                       | ocation of De                  | aur                                       | Harford                                  | Death                           |  |
| Funeral  | Social Security Number   | i. Sex 7.                                      | Age (In yrs. last  | birthday)                        | If Under 1 Year                               | If Under 24                    | Hrs. 8. Date of Bi                        | irth(MM/DD/YYYY)                         | 9. Birthplace (State or         |  |
| Director   | 218-25-8893  | 1XM 2F   | 20                 | Yrs.                             | Months Days                                   | Hours N                        | /lin.                                     |  | Foreign<br>Country)Maryland     |  |
|  | Usual Residence of Decedent  |  |                    |                                  |   |                                | TOCL.                                     | 22 <b>,</b> 1989                         |                                 |  |
| v any  | 10a. State 10b. County   |  | 10c. City, To      | wn or Locatio                    | n   |                                | •   |  | 10d. Inside City Limits         |  |
| land f sho   | New York Suffol  | ζ  | Sou                | nd Bea                           | ch  |                                |   |  | 1 Yes 2 X No                    |  |
| ne Maryland<br>or 28a-f show any<br>fired at once,   | 10e. Street and Number   |  |                    |                                  | 10f. Zip Code                                 |                                | 1   | 10g. Citizen of Wha                      | Country?                        |  |
| or death with the Maryland<br>or items 23s or 28s-f sh<br>Emust be notified at one<br>Funeral Director   | 86 Tyler Ave.  |  |                    |                                  | 11789   |                                |   | USA                                      |                                 |  |
| ath wi   | 11. Marital Status 1 X Never Married 2 Married   | 12. Was Deced                                  |                    | 13. Was                          | Decedent of Hispa<br>s, specify Cuban, N      | anic Origin? (<br>Mexican, Pue | Specify Yes or No<br>rto Rican, etc.)     | 14. Race - White,                        | American Indian, Black,<br>etc. |  |
| er des   | 3 Widowed 4 Divor  | 1 Yes  | 2 No               |                                  | res 2 X No                                    | s nooifi <i>r</i>              |   | Specify:                                 | White                           |  |
| urs afterural" amine   | 45.5   | or Dates                                       | completed) 16      | a. Decedent's                    | s Usual Occupation                            | n (Give kind o                 | of work done                              | 16b. Kind of Busin                       |                                 |  |
| 72 ho<br>n "na<br>al Ex  | Elementary/Secondary (0-12)  | College (1-4                                   | or 5+) 2           | during mp:<br>Aviati             | st of working life. D<br>On Operat            | O NOT use r                    | retired)                                  |  | ,                               |  |
| // ithin ene.  | 9800-15 Jededent's Education (Specify only highest grade completed)  163. Decedent's Usual Occupation (Give kind of during mpst of working life. Do NOT use re AVIation Operations  17. Father's Name (First, Middle, Last)  18. Mother's Name  |                    |                                  |   |                                |   |  | Government                      |  |
| Hygin Hygin Co   |  | ,  |                    |                                  | 18  | .Mother's Na                   | me (First, Middle,                        | Maiden Surname)                          |                                 |  |
| 2121<br>2121<br>ould be fil<br>Mental I<br>marked<br>ic event,   | Keith Robert Ki  |  |                    | 40h Mailian                      | 101   |                                | n Lynn Co                                 |  |                                 |  |
| MD 21215-0036 at 2 should be filed within 72 hours after death with the Maryland 1th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director  | 19a. Informant's Name/Relationship (Type, Print)  Keith R. Kunze Sy. / Father  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  86 Tyler Ave., Sound Beach, NY 11789   |  |                    |                                  |   |                                |   |  |                                 |  |
| and 2  | 20a. Method of Disposition   | / / rau  | 20b. Plac          | e of Dispositi                   | on (Name of ceme                              |                                | Date                                      | 20c. Location - C                        |                                 |  |
| DOFE<br>ages I<br>nt of F<br>t: If   |  | 3 Removal from                                 | Otate              | natory or othe                   |   |                                | 20.10                                     |  |                                 |  |
| New York Suffolk   Sound Beach   10f. Zip Code   11789   11899   118   |  |  |                    |                                  |   |                                | 30-10                                     | Calvert                                  | on, NY                          |  |
| inj India  |  | 211  |                    | MC 13                            | Comas Fur                                     | nerál 1                        | Home, P.Z                                 | A.<br>nadon Ma                           | 21000 Pare [ver                 |  |
| Physician  | 23a. Part I. Enter the disease, or confailure. List only one cause or  | mplications that caus                          | ed the death. Do   | not enter the                    | mode of dying, su                             | ich as cardiad                 | or respiratory am                         | est, shock, or heart                     |                                 |  |
| /Medical   | Immediate Cause (Final disease   | a. Multiple Injuri                             | es                 |                                  |   |                                |   |  | Between Onset and<br>Death      |  |
|  | or condition resulting in death)   | Due to (or as a co                             | nsequence of):     |                                  |   |                                |   |  |                                 |  |
| ē  | Sequentially list conditions, if any, leading to immediate   | b. Due to (or as a co                          | nsequence of):     |                                  |   |                                |   |  |                                 |  |
| ted<br>I<br>Innsit<br>Examiner   | cause. Enter Underlying Cause  | c  |                    |                                  |   |                                |   |  |                                 |  |
| t ansit  | events resulting in death) Last  | Due to (or as a cond.                          | nsequence of):     |                                  |   |                                |   |  | ,                               |  |
| on of Vital Records, P.O. Box 68760, cading Physician: The law requires that the death certificate be executed party or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transitation: To Be Completed by Physician/Medical Exitation:   | UNPENDED AMENDED AMENDED   |  |                    |                                  |   |                                |   |  |                                 |  |
| Box 68760, e death certificate be the attending physic ad for use as the burnysicial for yes in the burnysicial for the purple of the purple o | IF FEMALE:   | 23c. If yes, outo                              | come of pregnanc   | у                                |   |                                |   | 23d. Date of de                          | livery                          |  |
| 687<br>certific<br>iding p   | 23b. Was decedent pregnant in the past 12 months?  | 1 Live birth                                   |                    |                                  | death 3                                       | Ectopic preg                   | nancy                                     | Month                                    | Day Year                        |  |
| ). Box 6876 the death certificate by the attending phy ched for use as the Physician/M   | 1 Yes 2 No 9 Unkno   |  | at time of death   | 5 Othe                           | r (Specify)                                   |                                |   |  |                                 |  |
| O. B<br>at the de<br>by the<br>lached i  | Part II. Other significant condition   |  | ath but not result | ing in the und                   | lerlying cause give                           | en in Part I.                  | 23e. Did to                               | bacco use contribu                       | te to the cause of death?       |  |
| r, P.O<br>ires that t<br>signed by<br>I be detac   |  |  |                    |                                  |   |                                | 1 Yes                                     | 2 <b>V</b> No 3                          | Probably 4 Unknown              |  |
| Records, The law requires ficate has been sig , page 2 should be   |  |  | -                  |                                  |   | _                              | 24a. Was a                                |  | re autopsy findings available   |  |
| eco<br>he law<br>ate has<br>age 2 s  |  |  |                    |                                  |   |                                | autop<br>perfor<br>1 ✓ Yes                | m <u>ed</u> ? dea                        |                                 |  |
| of Vital Records, ag Physician: The law requirement of the this certificate has been a neral director, page 2 should the To Be Completed:  | 25. Was case referred to medical   | L  |                    |                                  | 26.Place of                                   | Death (Chec                    |   | 2 10 1                                   | Yes 2 No                        |  |
| Vita<br>hysici<br>this co  | examiner?<br>1 ✔ Yes 2 No  | Hospital: 1 Inpa                               | tient 2 ER/        | Outpatient :                     | DOA Oth                                       | ner <sub>4</sub> Nurs          | ing Home 5                                | Residence 6 (                            | Other:                          |  |
| After t<br>funeral   | 27. Manner of Death  1 Natural 5 Paradian  | 28a. Date of Ir<br>(Month, Day<br>Apr 23, 201  | njury 28b          | . Time of Inju                   |   |                                |   | now injury occurred driver collided      | 1 with car                      |  |
|  | 2 ✓ Accident 5 Pending   | ation  |                    | 06 hrs                           |   | 2 ✔ No                         | Wiotorcycle                               | diver comdet                             | with car                        |  |
| Division (pital or Attending ours after death. teral Director: Affilled in by the fun  | 3 Suicide 6 Could n  | ot be  |                    | farm, street,                    | factory, office build                         | ding, etc.                     | or Town, St                               | tate)                                    | or Rural Route Number, City     |  |
| 를 한 등 등 (P)  | 4 Homicide   | T(opoony) K                                    |                    |                                  |   |                                |   |  | oll Road, Joppa, MD             |  |
| To the Hos within 24 h To the Fur completely   | Check only   | ician: To the best of<br>er:On the basis of ex | camination and/or  | eath occurred<br>r investigatior | d at the time, date a<br>n, in my opinion, de | and place, ar<br>eath occurred | d due to the cause<br>at the time, date a | e(s) and manner as<br>and place, and due | stated. to the cause(s)         |  |
| To To Con  | 29b. Signature and title of certifier  | and manner state                               | d                  |                                  | 29c. License ni                               |                                |   |  | (Month, Day, Year)              |  |
|  | Chomo in the   | ( Ac 110                                       |                    |                                  | O.C.M.  | ≣.                             |   | April 24, 2010                           |                                 |  |
|  | 30. Name and address of person wh  | o completed cause of                           | f death (Item 23a) | )                                |   |                                |   |  |                                 |  |
| †1   |  | Assistant Medical                              |                    | 111 Pen                          | n Street, Balti                               | more, MD                       | 21201                                     |  |                                 |  |
| State<br>Registrar   | 31. Date filed (Month 41 B) Year   | 2010 32. Resist                                | rar's Signature    | . 100                            | Med   |                                |   |  |                                 |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                                |  |                  | State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar   |
|--------------------------------|--|------------------|--|
|                                | Physicis   | · /              | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death   |
| -                              | Physicia<br>Medic  | cal              | Bernice Gooding Karfgin Ap\\overline{A}\o  |
| ,                              | Examin   | er               | 4a. Facility Name (if not institution, give street and number) Pickersgill  4b. City, Town, or Location of Death Towson  4c. County of Death Baltimore   |
|                                | Funeral<br>Director  |                  | 5. Social Security Number 213-52-6913 6. Sex 1 Days Hours Number 2 |
|                                | ryland<br>-f show<br>ied at  | ctor             | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Maryland Baltimore 10c. City, Town or Location 10d. Inside City Limits  1 □ Yes 2 № No   |
|                                | the Ma<br>or 28e<br>e notif  | Dire             | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?   |
|                                | h with one 23a must b  | Funeral Director | 6003 Lakehurst Drive Unit 2 21210 U.S.A.   |
| 9800                           | within 72 hours after death with the Maryland<br>glene.<br>er than "natural", or items 23a or 28a-f show<br>, the Medical Examiner must be notified at | þ                | 11. Marital Status  1  Never Married 2  Married 3  Widowed 4  Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1  Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1  Yes 2  No Specify:  14. Race - American Indian, Black, White, etc. 1  Yes 2  No Specify:  |
| 15-(                           | 72 hoi<br>in "nat<br>Medica  | Completed        | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16b. Kind of Business Industry   |
| 212                            | s filed within 72 hour<br>tal Hygiene.<br>ed other than "natul<br>event, the Medical   |                  | 12 Office Manager Medical  |
| yland                          |  | To Be            | 17. Father's Name (First, Middle, Last)  Charles William Gooding, Jr.  18. Mother's Name (First, Middle, Maiden Surname)  Marie Brice  |
| e, Mar                         | ge 1 and 2 should be<br>it of Health and Men<br>If item 27 is marke<br>or other traumatic  |                  | 19a. Informant's Name/Relationship (Type, Print)  Fay Stephens / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  6003 Lakehurst Drive Baltimore, Maryland 21210   |
| Baltimore, Maryland 21215-0036 | Pag<br>ant:  |                  | 20a. Method of Disposition  1  |
| Bal                            | permit. Departr Importa any inju   |                  | 21. Signature of Funeral Scatter Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204  |
|                                | Medical<br>Examiner  | er               | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. END STAGE DEMENTIA  Due to (or as a consequence of):  FAILURE TO THRIVE   |
| 78,                            | cate be executed<br>physician and<br>s the burial-transit  | edical Examiner  | to any heading to in mediatical cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  |
| 200                            | cate be  | edica            | d  |
| P.O. Box 687                   |  | ⋝∣               | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves 2   No 9   Unknown   Unknow |
| ds, P.O                        | uires that the signed by all die deta  | ed by Pl         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown   |
| Division of Vital Records,     | ysician: The law requires<br>is certificate has been sig<br>director, page 2 should b  | Completed        | 24a. Was an autopsy findings available autopsy performed?  1  Yes 2  No  |
| tal                            | sician: The<br>certificate<br>rector, pag  | Be               | 25. Was case referred to medical examiner? 26. Place of Death (Check only one)   |
| of V                           | g Phys<br>er this c<br>eral dir  | e: 10            | 27. Manner of Death  28a. Date of injury  28b. Time of  28c. Injury of Death   |
| ono                            | eath.<br>or: Afte  | Certificate:     | 14 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation 3 Suicide 6 Could not be   |
| Divis                          | al or Att  |                  | 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |
|                                | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After thi<br>completed filled in by the funeral            | Medical          | 29a. Certifier (Check only ope)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |
|                                | To th<br>Withir<br>Comp  | <                | 20h Cignative and title of food in   |
|                                | <i>h</i>   |                  | KO79547 64-23-2010   |
|                                | 3  |                  | 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SUSAN ANTITOTY 6565 N. CHARLES ST. STE 4105 TOWSM, ND 21204  31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 27 200 Divining S. Sparker   |
|                                | Stat<br>Registra   | - I              | 31. Date filed (Month) Day, Year)  APR 27 2010  Server S. Signature  APR 27 2010  A |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15, 2010 Month **Physician** Dolly A. Lee 19:32 FM PEIL /Medical 4b. City Jown, or Location of Death
13 ALTIMORE 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES HOSPITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 12, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🔽 F Months Days Hours 60 West Virginia 214-50-5561 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, Ite Mactical Examinat must by notified at 1 Yes 2 No Director MD N/A Baltimore with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 490 S. Brunswick St. 21223 USA s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
Item 27 is marked other than "natural" or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earcel S. Shears Gladys G. Meneer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander L. Lee, Sr./husband 490 S. Brunswick St. Baltimore, MD. 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town State Pages nent of I permit. Pages Department of Important: If Its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 04-21-10 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Ambrose Funeral Home of Lansdowne Ze. 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HINKHOWN Acute Myoundlas /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any second conditions, if any second conditions are linear to the cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to for as a consecuence of death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2 ☐No 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 □ Yes Hospital or Attending Physician: ours after death.

neral Director; After this certific
filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes/ 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal and manner stated. within 2 To the

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

Sumar

19thm.

ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number

BP9619430

leath (Item 23a) (Type, Print)
South Cuton Avenue, Bultimore, manyland, 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1<sup>Day</sup> 2<u>010</u> Jean Adele Leidig April 24 7:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1112 W. 40th Street Baltimore Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea May 16, 1 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX** Days Hours Director Maryland 219-38-8509 1942 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director N/A Baltimore Maryland XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1112 W. 40th Street 21211 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify:White 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Green Spring Dairy 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Marsh Adele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Leidig Husband 1112 W. 40th Street, Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Atlantic Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/29/2010 Glen Burnie, Maryland 4 Conation 5 Other (Specify) 21. Signatura of Frineral Service Lice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due for as a consequer Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed Cancer 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hyperglycemia 24a. Was an **Director:** After this certificate has be in by the funeral director, page 2 s autopsy performed ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ⅓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours af Funeral Di eted filled ir Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2

To the I

State Registrar

only one) 29b. Signature and title of certifier

Craig Gold Do

APR 27

Mell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West

82. Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

H 53088

40th Street 4212 A Baltimore, Maryland 21211

29d. Date signed (Month, Day, Year) April 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Charles Peter Lach 24. 2010 2:28 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death
Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign July 30, Year) 1<u>922</u> 1X M 2 □ F Months Days Hours 87 **Director** 050-18-4219 Yrs Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Timonium 1 ☐ Yes 2XXNo 10e. Street and Number ò 10f. Zip Code Citizen of What Country? United States Funeral 23a 2110 Eastham Road 21093 of America items ? hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1.X. Yes 2 If Yes, Give Year or Dates. Black, White, etc. P, <u>^</u> 1 Never Married 2XXMarried 2 No white 1 ☐ Yes 2XXNo Specify: "natural" 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event; the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Agnes Bruczk Stanley Lach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mrs. Gloria L. Lach/ wife 2110 Eastham Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other pla Evans Funeral Chapel – Bel Air Aprilate 25, 1 Burial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Funeral Service License 22. Name and Address of Facility P.A. Teaceful Alternatives Funeral and Cremation Center, P.A. Mito 2325 York Road Timonium, Maryland 21093 Part II. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death \*Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed? Yes 2 No 2 🗆 No 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number,

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

Charles Lach

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

31. Date filed

(Check

only one 29b. Signature

and title of certifie

30/Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rud

possa

MO 3 300

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24Pay April 1 Robert Lancaster 2010 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death College Manor Lutherville Baltimore 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 538-26-3132 1 X M 2 🗆 F Days Hours Sept. 16 1930 Washington Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director Maryland 28a-f Baltimore Towson 1 Tes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1408 Autumn Leaf Road 21286 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Market once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Physician Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Scott G. Lancaster Mary Lamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Lancaster / Son 14130 Twisting Lane Dayton, Maryland 21036 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗀 Removal from State Dulaney Valley Mem. Gdns. Timonium, Maryland 4/30/10 4 Donation 5 Other (Specify) 21. Signature of Funeral Sa 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) month VNG Medical Due to (or as a consequent of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician thed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 2 No 1 ☐ Yes 2 ☑ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special Control of the Control 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be execufed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760

Charles St. 31. Date filed (Month, Day, Year) 32. Regiarar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar (Check

29b. Signature and title of certifle

uns)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number